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ABSTRACT

This special report is designed to clear up misconceptions about the acquired immune deficiency syndrome (AIDS). Chapter One provides the facts: how many children have AIDS, how AIDS spreads and how it doesn't spread, and who gets AIDS. While new developments occur constantly in AIDS research, experts are convinced of the central fact presented in Chapter One: AIDS is not spread by casual contact. Chapter Two describes how the AIDS crisis has affected schools thus far. It details how the U.S. Centers for Disease Control recommends schools handle students and employees with AIDS, and summarizes a variety of state and local responses to the disease. Chapter Three examines, in depth, how two local school districts dealt with children with AIDS, and shows how their radically different approaches produced radically different results in their communities. Chapter Four provides up-to-date information on AIDS litigation and includes predictions from attorneys about what school officials can expect next. Chapter Five explains why it is crucial to have an AIDS policy before a student or employee becomes infected with AIDS and offers step-by-step recommendations for drawing up a policy that considers school district needs. Chapter Six indicates why schools should educate their students and employees about AIDS whether or not they have an AIDS case on campus. It tells what the experts think: that schools have the power to stop the spreading of AIDS through the right kind of education. Chapter Seven reveals the unique problems colleges and universities face in dealing with AIDS. It examines what college officials and students have done to set up policies and educate their communities about AIDS. And it details the recommendations of the American College Health Association. Recommendations to help schools deal with AIDS are scattered throughout the book, and the report ends with a section of recommended actions every school administrator can take to better control the kind of impact AIDS has on his/her school. Twelve appendices provide numerous guidelines, statements, directories and other resources. (RH)

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AIDS:

IMPACT ON THE SCHOOLS

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* * *

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* * *

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Introduction

The generation now in our schools, not only students but younger teachers and administrators as well, is unfamiliar with the spectre of epidemic diseases that kill.

So the spread of Acquired Immune Deficiency Syndrome (AIDS) like wildfire through certain groups of our population has spread fear even faster through all segments of the country.

This generation is the healthiest and most fitness-conscious ever. The sight of young people dying from an incurable disease is even more shocking under these circumstances.

Long-time educators, however, remember a previous reign of terror.

"Anyone under 40 has lived in a society basically free of epidemics. But anyone over 40 can remember serious epidemics of smallpox and scarlet fever and measles and polio," said Scott Thomson, executive director of the National Association of Secondary School Principals. "The most frightening thing for a young person my age growing up in the 1930s and 1940s, the most frightening thing, was polio, because it was a disease that hit young people. No one knew how to prevent it."

This description of the polio panic that in 1916 overtook New York City—site of one of the nation's worst epidemics—should strike a familiar chord in these days of hysteria over AIDS:

> When threatened by contagion which kills or leaves its victim permanently disabled and against which medicine offers neither prevention nor cure, one's natural inclination is to flee. As soon as the extent of the epidemic became publicly known, thousands of New York families fled to outlying areas, frequently taking infection with them and spreading it. Others did not leave the city but fled into their homes, shut the windows, drew the blinds, and locked the doors. There was no certainty that any hospital would even give a victim a bed, so great was the fear of infection. ... Meanwhile, outlying communities began treating New York City refugees as if they were lepers or vagrants, turning them back with guns (Richard Carter, *Breakthrough: The Saga of Jonas Salk*, New York: Trident Press, 1965, p. 10).

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Then, like now, fear overtook reason.

But at least in the early 1900s, the fear had some basis. Polio did spread from child to child, and, for a long time, no one knew how it spread. AIDS, on the other hand, has *never* spread from child to child or indeed from adult to adult without the sharing of bodily fluids, either sexual secretions or blood.

Despite the evidence that the AIDS virus needs intimate contact to spread (detailed in Chapter One), confusion is rampant for many reasons.

Many doctors and scientists without credentials in AIDS research have jumped into the fray, confusing the public with assertions that quarantines are necessary to protect children from their infected classmates. The mass media, through its very nature, has presented new findings on AIDS in 30-second snippets that fail to convey the complexity of the data. And educators, mindful of their duty to protect the health and safety of students under their care, are reluctant to act in such a state of confusion.

"AIDS is separate and distinct from other diseases because it is incurable. That weighs heavily with a school district," said Ted Comstock, a school board member from Nampa, Idaho, and immediate past president of the National School Boards Association. "This isn't a matter of ignorance. It's a matter of protecting our students, protecting the integrity of our school system."

* * *

A cartoon making the rounds of educators in Washington asks: "What can be spread by casual contact: AIDS or AIDS hysteria?" The answer: clearly, AIDS hysteria.

August Steinhilber, associate executive director of the National School Boards Association, said his group was "appalled at the misinformation, fear, sensationalism and demagoguery that has surrounded the issue." To take a step toward ending that situation, NSBA held the first all-day national forum for educators on the subject in February 1986.

Following suit was the National PTA, which invited top AIDS expert Dr. Martha Rogers, head of the pediatric AIDS program at the U.S. Centers for Disease Control in Atlanta, to speak at its

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annual legislative conference in March 1986. That invitation, and others like it, "shows me that educators are looking at it seriously and taking a hard look at the problem," Rogers said. "They want experts to talk to them. They're not just sort of stonewalling. I see that as a good sign."

This special report from the Education Research Group of Capitol Publications is designed to clear up the misconceptions about a disease that *should* frighten us, but not for the reasons many *are* frightened.

■ Chapter One gives you the facts: how many children have AIDS, how AIDS spreads and how it doesn't spread, and who gets AIDS. While new developments occur constantly in AIDS research, experts are convinced of the central fact presented in Chapter One: AIDS is not spread by casual contact.

■ Chapter Two tells you how the AIDS crisis has affected schools so far. It details how the U.S. Centers for Disease Control recommend schools handle students and employees with AIDS, and summarizes a variety of state and local actions so far on AIDS.

■ Chapter Three examines, in-depth, how two local school districts dealt with children with AIDS, and shows how their radically different approaches produced radically different results in their communities.

■ Chapter Four brings you up to date on the AIDS litigation that has occurred so far and includes predictions from top attorneys in the field as to what school officials can expect down the road.

■ Chapter Five explains why it's crucial to have an AIDS policy before you are faced with a student or employee with AIDS and gives you step-by-step recommendations for drawing up a policy that considers the needs of your district.

■ Chapter Six tells you why schools should educate their students and employees about AIDS whether or not they have an AIDS case on campus. It tells you what the experts think: that schools have the power to stop the spread of AIDS through the right kind of education.

■ Chapter Seven reveals the unique problems colleges and universities face in dealing with AIDS, because students are older and live in close quarters with each other. It examines what

college officials and students on a variety of campuses, both public and private, have done to set up policies and educate their communities about AIDS. And it details the recommendations of the American College Health Association, an organization that is way ahead of most school groups in coming to grips with the issue of AIDS and education.

* * *

Recommendations to help guide schools through the thorny issue of AIDS are scattered throughout the book, and this special report ends with a section of recommended actions every school administrator can take to better control the kind of impact AIDS has on your school. Before making any decisions, of course, consult with medical and legal experts for the most up-to-date information available.

The Facts Behind The "Mystery" Disease

A major misconception about AIDS is that scientists don't know anything about it, that it's a mystery disease:

AIDS, or Acquired Immune Deficiency Syndrome:
A — Acquired, not hereditary or caused by medical treatment
I — Immune, the body's defense against disease
D — Deficiency, lacking cellular immunity
S — Syndrome, the set of diseases that signal the diagnosis

"There's been a lot of discussion over the past couple of years about how little scientists know about this virus. Well, that is really quite a misconception," said Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health.

How AIDS Infects The Body

One thing scientists have discovered is that the disease is caused by what they call the HTLV-III/LAV virus. That cumbersome name stands for the even more cumbersome Human T-Cell Lymphotropic Virus, Type III/Lymphadenopathy-Associated Virus.

The complexity of the name mirrors the complexity of the disease.

But the bottom line is straightforward: The virus destroys the body's ability to fight off disease. AIDS in and of itself does not kill. Instead, it makes its victims vulnerable to some of the deadliest diseases yet encountered in humans by attacking the

body's white blood cells, the cornerstone of the immune system's defense against disease.

Scientists believe the virus targets the T-4 "helper" white blood cells (see Figure 1). The helper cells' job is to stimulate the B-Cells, another kind of white blood cell, to produce antibodies to fight germs.

Scientists consider the virus's choice of the helper T-Cells the most dangerous selection because the cells, in a healthy person, sound the warning of infection to the rest of the white blood cells. Without functioning helper cells, the B-cells aren't triggered to produce antibodies to fight the invader.

"The helper cells can be described as sort of as an orchestra leader. They direct the rest of the symphony," said Dr. Martha Rogers, an epidemiologist who heads the pediatric AIDS unit at the U.S. Centers for Disease Control (CDC). "When the helper cells are gone, you are left with instruments playing on their own."

How AIDS Reveals (Or Doesn't Reveal) Itself

The virus can take two basic approaches to a cell. It can enter the cell, replicate itself, kill the cell and destroy the immune system. That's what happened in the more than 20,000 people who have what scientists call "full-blown" AIDS.

The second approach is for the AIDS virus to insert itself into the genetic material of the cell and "kind of sit around there and not do much," as NIH's Fauci puts it. That's what up to 1 million people who are infected but asymptomatic have going on in their white blood cells.

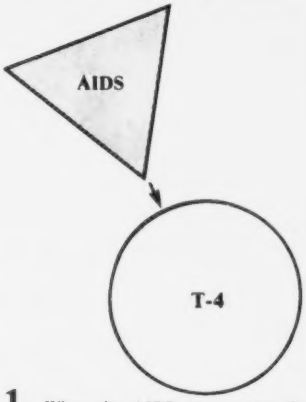
In fact, the vast majority of people who have been infected with the virus have no symptoms. Most don't even know they have been infected.

CDC estimates that as of May 1986, more than 20,000 people have come down with full-blown AIDS, up to 150,000 people have AIDS-Related Complex (ARC), and up to 1 million are asymptomatic carriers of the virus.

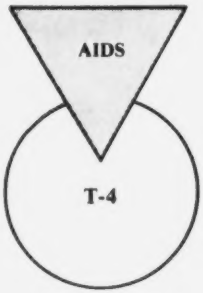
■ "Full-blown" AIDS refers to the disease as most people are familiar with it. The AIDS virus has invaded the body and destroyed the helper cells, leaving the patient unable to fight disease. The patient typically has one or more of what are known as opportunistic infections, diseases a person with a normal

Figure 1

How The AIDS Virus Attacks The Human Immune System

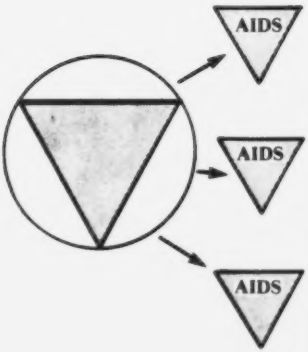


1. When the AIDS virus enters the bloodstream, it attaches itself to a T-4 lymphocyte, the white blood cell that controls the immune system.

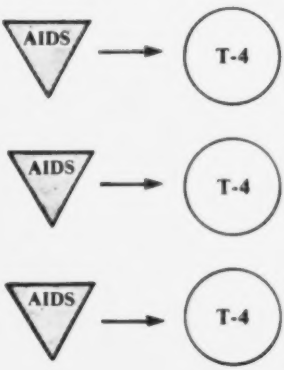


2. The virus penetrates the T-4 cell, destroying its genetic structure and replacing it with instructions to reproduce the AIDS virus.

Design by Leslie A. Ratzlaff and Aden Hachman



3. The converted T-4 cell, which may remain dormant for several weeks to several years, copies the deadly invader, giving birth to new AIDS virus cells.



4. The newly produced AIDS viruses attack other T-4 cells and weaken the immune system. As the process is repeated in new cells, the original host T-4 cell dies.

immune system will almost never get. Or he or she may get a severe cancer that, again, is extremely rare in non-AIDS patients. One cancer that has received a lot of attention is Kaposi's sarcoma, which because it typically is seen only in men over age 50, helped clue scientists in to AIDS when it started appearing in young men.

- ARC refers to the huge spectrum between full-blown AIDS and asymptomatic carriers. People with ARC don't have full-blown AIDS with the serious opportunistic infections or cancers, but have certain symptoms of lowered immunity, such as weight loss and fatigue.

- Asymptomatic carriers are actually the most dangerous to other people; they often don't know they're infected, so they continue their same sexual practices and could be spreading the disease unwittingly to their partners.

A blood test has been developed to detect antibodies to the AIDS virus, but public health officials recommend the test only for those in high-risk groups because of the disease's rarity among others.

Not everyone who tests positive for the antibody still has detectable virus in their blood, but public health officials consider anybody with the antibody infectious, out of the sheer difficulty of finding out who has the virus. An experimental test for the virus is used by researchers, but because of its high costs—about $200 compared to about $6 for the antibody test—it is unlikely to come into general use soon. "We tell them you're very likely to have the virus in your blood and you should act to prevent spreading it," Rogers said.

Clearly, the number of people with full-blown AIDS is just the tip of the iceberg. Indeed, when CDC scientists go around to school or other community groups to discuss AIDS, they show a slide of an iceberg. The tiny, uppermost tip represents those with full-blown AIDS, while the massive mountain-like structure underneath represents the large number of ARC and asymptomatic carriers. Bear in mind that asymptomatic carriers, while they can spread the disease, might never develop AIDS themselves.

How AIDS Is Spread

Most people have heard by now that AIDS is not spread by casual contact. The trouble is, many people don't really believe

it. News stories have been contradictory; scientists have been contradictory. Nonetheless, the top AIDS researchers are in agreement: you can't get AIDS by shaking someone's hand, or sharing a book, or even from hugging an AIDS patient.

Scientists do know that AIDS is transmitted in three ways: through sexual contact, blood or blood products, and from an infected mother to her child probably before or during birth.

1. AIDS is a sexually transmitted, or venereal, disease. A full three-quarters of U.S. adult patients and 17 percent of U.S. school-aged patients—6 to 18 years old—got AIDS through sexual transmission (see Figure 2), usually anal intercourse between two men. There have, however, been cases of heterosexual transmission in this country, usually through vaginal intercourse. In Africa, the disease is just as common in women as in men.

Figure 2
AIDS Patients, By Age Group And Risk Factor
As Of February 19, 1986

Risk Factor	Preschool-age Children (0-5 years)	School-age Children (6-18 years)	Adults (19+ years)
Sexual Transmission	0	10 (17%)	12,904 (75%)
IV Drug Use	0	3 (5%)	2,937 (17%)
Hemophilia	2 (1%)	25 (42%)	122 (1%)
Blood Transfusion	34 (15%)	5 (9%)	275 (2%)
Perinatal	179 (79%)	10 (17%)	0
Unknown*	13 (5%)	6 (10%)	993 (5%)
Total	**228 (100%)**	**59 (100%)**	**17,231 (100%)**

** When a case of AIDS is reported to the U.S. Centers for Disease Control as being caused by an unknown risk factor, CDC sends an investigator to interview the patient. As a result, most cases are reclassified under one of the known risk factors. Some patients, however, remain classified as unknown because they died before they could be interviewed, while others may have concealed information about their exposure to the AIDS virus.*

Note: Figures include all AIDS patients reported to CDC since the disease was first identified in 1981.

Source: U.S. Centers for Disease Control

2. AIDS is a blood-borne disease, which means you can get the disease if your blood is exposed to contaminated blood. Seventeen percent of adult AIDS patients and 5 percent of school-aged patients got the disease through sharing needles used to inject drugs. "The reason is that people who use drugs like heroin do it in a group. They pass the syringe around the room. If you're the last person in the room to get the needle, you get blood from everyone in the room," explained Rogers.

Forty-two percent of school-age AIDS patients got the disease from a clotting agent used to treat hemophilia.

Another way the AIDS virus enters the blood is through a transfusion of contaminated blood. Only 2 percent of adult AIDS patients got the disease that way, while 9 percent of the school-aged AIDS population and 15 percent of the preschool patients were infected through transfusions. This has become a less common way to get AIDS because blood donors are now being tested for the AIDS virus. In fact, there has not been a single confirmed case of AIDS transmission through a blood transfusion reported to CDC since screening of blood donors began in March 1985, according to Rogers.

The last way the AIDS virus gets into the blood is the most common way for school-age patients: from contaminated Factor VIII, a clotting agent, made from the blood of thousands of donors, that hemophiliacs need to stay alive. Forty-two percent of school-age AIDS patients got the disease that way, as did 1 percent of preschool patients and 1 percent of adult patients. A "devastating" problem for hemophiliacs, AIDS currently rivals bleeding as their number one cause of death, according to Dr. Harold Jaffe, chief of the epidemiology branch at CDC's AIDS program.

Again, though, precautions have been put into place to keep the Factor VIII supply clean, and CDC expects this category to eventually decrease to almost nothing, Rogers said.

3. AIDS can be transmitted perinatally (around the time of birth). The vast majority of preschoolers with AIDS—79 percent—got it from their infected mothers either during pregnancy, during birth, or soon after birth, possibly through breastfeeding. Seventeen percent of AIDS-infected children now of school age got the disease perinatally. Most AIDS

transmitted this way is diagnosed by age 2. And most infants who get AIDS this way die before they reach school age.

How were their mothers exposed to the AIDS virus to begin with? Sixty-one percent were IV drug users, 22 percent were born in Haiti (where the disease is more widespread than in the United States among both homosexuals and heterosexuals), 11 percent had a sexual partner who used IV drugs, 4 percent had a bisexual partner, 1 percent received a contaminated transfusion, and 1 percent haven't admitted to any risk, according to CDC figures.

Infected mothers do not always transmit the virus to their children. In fact, CDC estimates it only happens about 25 percent of the time. Even so, women with the AIDS virus, even if they have no symptoms of the disease, should very carefully consider whether to get pregnant, according to Rogers.

"Some women who want children very badly will elect to take" a high risk, she said. "It's a big decision. Besides the risk to the baby, they have to consider that they themselves could die, leaving their child uncared for. Pregnancy in itself causes immunosuppression [impairment of the body's immune system] in normal women. That, coupled with what the virus is doing, could cause them to get worse. They could go from asymptomatic to having symptoms."

How AIDS Is NOT Spread

There is no evidence that AIDS can be spread through casual contact. Nonetheless, such a statement drives school officials to distraction, because it doesn't say, "AIDS absolutely, 100 percent, cannot be spread through casual contact."

In science, however, nothing is 100 percent. Jaffe terms the chance of getting AIDS through casual contact "remote." Dr. Mervyn Silverman, national spokesman for the San Francisco-based American Foundation for AIDS Research, said, "There has not been one single case of AIDS spread through casual contact."

The public has been confused by reports of the AIDS virus being found in tears and saliva. "If a child with AIDS spits or cries on another child, can the other child get AIDS?" is a common question of educators.

While it's true the virus has been found in tears and saliva,

there have been no cases of the virus spreading that way, said Silverman, a former San Francisco health commissioner. "It's not only homosexuals and IV drug users who are spat upon and cried on," he said, but they're basically the only ones coming down with AIDS. One way to look at the risk, he said, is to compare your chance of being killed in an automobile accident, 1 in 3,000, with your chance of dying from AIDS (if you're not in a high-risk group or exposed to someone in a risk group), 1 in a million.

If students don't inject drugs and don't have sex with an infected person, they're more likely to be hit by lightning than to get AIDS.

"When I hear parents say, 'Can you guarantee that my son or daughter won't get AIDS?' I say, 'No I can't guarantee it, but I also can't guarantee'" that they won't be in a bus accident on the way to school.

But if students don't inject drugs from dirty needles and don't have sex with an infected person, they're more likely to be hit by lightning than to get AIDS, Silverman said.

The evidence that AIDS cannot be spread through casual contact is quite convincing.

Of the thousands of health care workers in daily contact with AIDS patients, including dozens who have stuck themselves with needles contaminated by AIDS patients' blood, only one nurse has come down with AIDS, and she actually injected the contaminated blood.

And of thousands of family members in daily contact with AIDS patients, none has come down with the disease except sexual partners and babies who are believed to have been exposed to the virus perinatally. In one study, such families shared everything: toothbrushes, razors, nail clippers, combs and so forth (See Figure 3).

The study, reported in the Feb. 6, 1986, New England Journal of Medicine (314: 344-9), found that of 101 persons who shared homes with AIDS patients but were not sexual partners, one 5-year-old boy had evidence of infection. He probably got the disease perinatally, said the study, which concluded that those who share homes with AIDS patients "are at minimal or no risk of infection."

So, Who Gets AIDS?

The issue is mainly who gets AIDS through sexual transmission. The other categories are self-explanatory: people are at risk if they share dirty needles, are born to a mother with AIDS, or get contaminated blood or blood products. Again, those who

Figure 3
Type Of Contact With AIDS Patients Among 101 Household Members
February 1986

Activity	Percentage Of Members In Activity
Sharing of household items	
Razors	9%
Toothbrushes	7
Nail clippers	42
Combs	51
Towels	37
Clothes	15
Eating utensils	25
Eating plates	46
Drinking glasses	48
Sharing of household facilities	
Bed	37
Toilet	90
Bath or shower	92
Kitchen	93
Washing items used by patients	
Dishes	65
Toilet	49
Bath	55
Clothes	38
Interacting with patient	
Helping to bathe	10
Helping to dress	16
Helping to eat	13
Shaking hands	21
Hugging	79
Kissing on cheek	83
Kissing on lips	17

Note: Household members' contact with AIDS patients, as of Feb. 6, 1986, had never resulted in a confirmed case of AIDS infection.

Source: New England Journal of Medicine, Feb. 6, 1986 (314:346)

need transfusions or other blood products are now at very little new risk because the blood supply has been cleaned up.

Figure 2 shows that 75 percent of adults who get AIDS get it through a sexual contact. Only 2 percent of adults get it through heterosexual contact. But it should be made clear that these figures are only for the United States. For reasons not fully understood, AIDS is widely spread heterosexually in Africa, where the ratio of those with full-blown AIDS is one to one, male to female. In this country, the few women who get AIDS use IV drugs or have a sexual partner who is bisexual or uses IV drugs.

Overall, 73 percent of all U.S. adults who get AIDS get it through male to male homosexual contact.

There are a number of theories to explain this. First of all, gay men routinely engage in anal sex and other sexual practices that lead to rupturing of tissue and bleeding. Gay men who are the receivers of anal sex are at higher risk, according to CDC's Jaffe.

Second, gay men tend to have multiple sex partners. While you can get AIDS from one exposure, the more exposures, the greater the risk.

That doesn't mean women can't get—and spread—the disease through sexual contact. Women who have sex with a man who's had even one homosexual encounter or uses IV drugs can be at risk. Men who have sex with a woman who uses IV drugs or has had contact with a man at risk can be at risk. And the chain goes on.

How To Keep From Getting AIDS

The basic two ways to keep from getting AIDS are to abstain from sexual relations with an at-risk person and to avoid sharing dirty needles.

But sexual abstinence, while chosen by some, is rejected by many. Instead, the gay community nationwide has taken the lead in publicizing what is known as "safe sex," activities that reduce the chance of contracting or transmitting AIDS through sexual relations.

The basic precept of safe sex is "know your partner," said Dr. Richard Keeling, chairman of the AIDS Task Force of the American College Health Association.

A safe sex brochure distributed by the Gay Men's Health Crisis in New York City puts it like this: "Know your partner, his state of health, his lifestyle and how many different sexual partners he has. If you enjoy being with a partner, see him again. The fewer different partners, the less your risk of acquiring a disease."

Indeed, the more partners you have, the greater your risk of contracting AIDS, according to the U.S. Public Health Service (PHS). The PHS recommends persons who suspect they or their partner have been exposed to the AIDS virus protect themselves during sex by avoiding contact with each other's body fluids (including semen, blood, feces and urine), by using condoms, and by avoiding oral-genital contact, open-mouth kissing, and sexual practices that may cause injury or rips in tissue.

Experts say schools, by getting the information about "safe sex" out to students, can help prevent the spread of the disease (see Chapter Six). Education works, according to San Francisco's Silverman, who cited a study of gay men who had been given "safe sex" information. Of those whose blood tested negative for the AIDS antibody before the education, 95 percent stayed negative after the education.

How Many People Have AIDS

As of May 1986, CDC estimated that more than 20,000 people, including 300 children, had come down with full-blown AIDS. At that time, CDC projected that the number of cases of AIDS would more than double in a year. The projections hold for children as well as adults.

Cases have been reported in all 50 states and the District of Columbia, although AIDS still tends to be a fairly localized problem, with New York and California having almost 60 percent of all reported cases (See Figure 4). New Jersey, Florida and Texas follow, with about another 18 percent divided equally among the three states. No other state has more than 2 percent of all the cases nationwide, according to CDC data.

Where AIDS Came From

AIDS seems like it just appeared out of nowhere, with the first AIDS cases in the United States being reported in 1981.

"We don't know where it originated," but the most common

theory is Africa, said NIH's Fauci. Scientists first heard of the disease when "dramatic" numbers of both men and women in certain African countries started coming down with it in the mid-1970s, he said.

It appears the disease went from Africa to Haiti in the late 1970s and then into the United States, where it quickly gained a hold in urban gay communities and then among intravenous drug users.

Progress (Sure But Slow) Toward A Vaccine

It seems that nearly every week, headlines report new breakthroughs in AIDS research. So far, however, those breakthroughs have been very preliminary when it comes to actually developing a vaccine.

The first step of vaccine research is understanding what you're up against, and that's where all those breakthroughs have

Figure 4
AIDS Cases Reported, By State
March 31, 1986

State	Adult/Adolescent		Pediatric*		Total	
New York	6,154	(33%)	111	(41%)	6,265	(33%)
California	4,272	(23)	20	(7)	4,292	(23)
Florida	1,220	(7)	38	(14)	1,258	(7)
New Jersey	1,117	(6)	36	(13)	1,153	(6)
Texas	1,059	(6)	7	(3)	1,066	(6)
Pennsylvania	426	(2)	7	(3)	433	(2)
Illinois	416	(2)	4	(1)	420	(2)
Massachusetts	369	(2)	9	(3)	378	(2)
District of Columbia	341	(2)	4	(1)	345	(2)
Georgia	314	(2)	2	(1)	316	(2)
Maryland	267	(1)	2	(1)	269	(1)
Virginia	217	(1)	5	(2)	222	(1)
Washington	219	(1)	—	—	219	(1)
Puerto Rico	212	(1)	4	(1)	216	(1)
Louisiana	207	(1)	3	(1)	210	(1)
Connecticut	200	(1)	7	(3)	207	(1)

Figure 4 (Cont.)

State	Adult/Adolescent		Pediatric*		Total	
Colorado	162	(1%)	1	(0)	163	(1%)
Michigan	137	(1)	1	(0)	138	(1)
Ohio	126	(1)	1	(0)	127	(1)
North Carolina	109	(1)	—	—	109	(1)
Arizona	99	(1)	—	—	99	(1)
Missouri	98	(1)	1	(0)	99	(1)
Minnesota	89	(0)	—	—	89	(0)
Indiana	71	(0)	1	(0)	72	(0)
South Carolina	65	(0)	4	(1)	69	(0)
Oregon	66	(0)	—	—	66	(0)
Hawaii	57	(0)	—	—	57	(0)
Oklahoma	45	(0)	—	—	45	(0)
Alabama	44	(0)	—	—	44	(0)
Wisconsin	41	(0)	—	—	41	(0)
Kentucky	38	(0)	—	—	38	(0)
Tennessee	38	(0)	—	—	38	(0)
Utah	34	(0)	2	(1%)	36	(0)
Nevada	30	(0)	—	—	30	(0)
Rhode Island	27	(0)	—	—	27	(0)
Delaware	25	(0)	—	—	25	(0)
New Mexico	24	(0)	—	—	24	(0)
Kansas	22	(0)	—	—	22	(0)
Iowa	20	(0)	1	(0)	21	(0)
Arkansas	18	(0)	—	—	18	(0)
Maine	17	(0)	—	—	17	(0)
Alaska	16	(0)	—	—	16	(0)
Mississippi	16	(0)	—	—	16	(0)
New Hampshire	14	(0)	1	(0)	15	(0)
West Virginia	13	(0)	1	(0)	14	(0)
Nebraska	13	(0)	—	—	13	(0)
Other States/Territories	26	(0)	—	—	26	(0)
Total	**18,610**	**(100%)**	**273**	**(100%)**	**18,883**	**(100%)**

** Pediatric AIDS cases include patients under 13 years of age at the time of diagnosis.*

Source: U.S. Centers for Disease Control

been. Everything you've read so far in this chapter is the result of incredible progress in unlocking the secrets of the once-totally mysterious virus.

But development of a vaccine is slow, and "appropriately so," said Dr. John E. Nutter, acting chief of the Prevention Branch of the National Institute of Allergy and Infectious Diseases' AIDS program.

Researchers must progress from the test tube and lower animals to chimpanzees—the only research animal whose reactions will prove anything regarding human response to the AIDS vaccine—and then three phases of human tests, Nutter said. The human tests alone take several years, to ensure first safety, then proper dosage, and then, effectiveness.

"The first good indication of when a vaccine will be available to the public is when you have one that is effective" in chimpanzees, Nutter said. "If we could come up tomorrow with something that is effective in chimpanzees, it would take two to five years before we could consider getting it out to the public."

With AIDS, "the situation is very complicated," said Nutter, because researchers still don't know exactly how the human immune system reacts to the virus. "Consequently, it's my view that all efforts now are based on theory and comparisons with other viral systems."

The good news is that although "we are a way off from an effective vaccine . . . there is enough research going on now" to encourage optimism that a vaccine will be found, Nutter said.

Federal Money For AIDS Research

While federal researchers are justifiably proud of the long way they have come in uncovering many of the facts behind the AIDS virus, advocates for the gay community are outraged that the Reagan administration has proposed cutting federal AIDS research support.

President Reagan's proposed fiscal 1987 budget calls for $213 million for AIDS research, a 12.7 percent cut from the $244 million Congress appropriated for fiscal 1986 (see Figure 5). The administration doesn't bill its budget as a cut from fiscal 1986, however, because it also is calling for rescissions that would lower the fiscal 1986 AIDS research budget to

Figure 5
Federal Funding For AIDS-Related Activities
1982 to 1987
(dollars in thousands)

Department of Health and Human Services	1982 Expenditures	1983 Expenditures	1984 Expenditures	1985 Estimated Expenditures
Alcohol, Drug Abuse and Mental Health Administration	$ 0	$ 516	$ 2,791	$ 3,242
Food and Drug Administration	150	350	798	9,005
Centers for Disease Control	2,050	6,202	13,750	33,231
National Institutes of Health	3,355	21,668	44,121	63,501
Office of the Secretary (demonstration projects)	0	0	0	0
Total	**$5,555**	**$28,736**	**$61,460**	**$108,979**

Department of Health and Human Services	1986 Congressional Appropriations	1986 President's Recommendation*	1987 President's Recommendation
Alcohol, Drug Abuse and Mental Health Administration	$ 12,704	$ 12,000	$ 13,000
Food and Drug Administration	10,015	10,000	10,000
Centers for Disease Control	64,925	50,000	46,000
National Institutes of Health	140,723	121,000	144,000
Office of the Secretary (demonstration projects)	16,000	0	0
Total	**$244,367**	**$193,000**	**$213,000**

** Contains $41 million in rescissions for fiscal 1986 and $10 million in cuts to comply with the Gramm-Rudman-Hollings balanced budget act.*

Note: Figures for fiscal years 1986 and 1987 are not yet final.

Source: Department of Health and Human Services.

$193 million. Thus, the fiscal 1987 budget is being billed as an increase in funding for AIDS research.

"Don't be fooled: this is budget sleight-of-hand at its worst," warns an AIDS Action Alert from the AIDS Action Council, a Washington, D.C.-based coalition of gay rights groups. "There is a huge difference—in lost lives most importantly, not to mention the vital research and education that might save them—between $244 million and $193 million in 1986 or even between $244 million and the $213 million being proposed for 1987. The fact is, the administration wants to slash funding in the very budget categories that most urgently require increases now."

Dr. Nutter of the National Institute of Allergy and Infectious Diseases does not see the situation as so grim. "You can always use more money, but we're moving as quickly as we can. About as quickly as science can permit."

A more serious limitation than budget cuts, Nutter said, is the lack of researchers with both the expertise and the interest to work on AIDS research. But he said there has been some turnaround: "We're starting to see some movement toward attracting people to AIDS research. Scientifically, it's a very interesting disease. The more intriguing, the more complex the problems, the more people are attracted to them."

Conclusion

Understanding how AIDS works is a crucial first step to making rational decisions about how to treat students and staff who come down with the disease.

The education, however, can't stop with school administrators. It must be spread from school board members to attorneys to principals to teachers and—key to raising awareness—to students and parents.

Chapters Two through Six will discuss how schools are struggling to deal with the AIDS crisis; how ignorance of how the disease works has caused many schools to make the wrong decisions; and how some schools are forging ahead boldly to educate their students and staff.

"I tell people who call me, you really need to get in there and start educating before you have a problem," said CDC's Rogers. "When people are educated, you have half the problem solved."

Chapter Two

How the AIDS Crisis Has Affected Schools So Far

Schools that made decisions on AIDS before the U.S. Centers for Disease Control (CDC) came out with its guidelines in August 1985—and Ryan White's school in Kokomo, Ind., was among them—could plead ignorance.

They were completely justified in saying medical experts were divided on how AIDS spread, because all they had to go on was what they read in the newspaper.

Now, that's no longer the case, as AIDS experts agree the disease is not spread through casual contact. And all AIDS experts agree there is no reason to keep the vast majority of students or staff with AIDS out of school.

The CDC Guidelines For Schools

Based on the medical evidence that AIDS cannot be transmitted by casual contact, CDC in August 1985 published two sets of guidelines—one for students and one for employees—for schools to use in formulating an AIDS policy (reprinted in full in Appendices A and B).

CDC recommends that schools lean toward keeping students in the classroom. For most school-age children with AIDS, said CDC, the benefits of attending school outweigh the risks of their catching infections from other students, and the benefits certainly outweigh "the apparent nonexistent risk" of other students contracting AIDS from them.

On the other hand, CDC recommends a more restricted setting for preschoolers and some neurologically handicapped children who lack control of their body secretions, who bite others, or who have oozing lesions that cannot be covered.

CDC does not recommend schools screen children for AIDS as a condition for entry.

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The guidelines call on schools to:

- Use a team made up of the child's physician, public health personnel, the child's parent or guardian and school personnel to decide where and how the child should be educated based on the child's behavior, neurological development and physical condition, and the expected type of interaction with others.

- Put into place routine procedures for cleaning up any child's blood or other body fluids.

- Regularly evaluate AIDS-infected children to see if their need for a more or less restricted setting has changed because they have matured, or because their condition has deteriorated.

- Inform and educate employees about the infection, in cases where employees feed or change the diapers of an AIDS-infected child.

- Keep to a minimum the number of employees who know about the child's condition, to ensure the child's right to privacy. Ensure confidentiality of records.

- Educate parents, children and educators about AIDS and its transmission, whether or not an infected child is in the district. "Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others." (For more on how to educate the school community, see Chapter Six.)

For employees, the CDC guidelines, which focus mainly on health care workers, make it clear that there is "no known risk" of transmission in settings such as schools. Because AIDS is not spread by casual contact, "workers known to be infected ... should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains."

Similarly, food service workers should not be restricted from work unless they have evidence of other infection or illness that is transmitted through the preparation or serving of food, say the CDC guidelines.

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But many school officials—having the same concerns as many in the general population—still fear they are putting other

children or employees at risk if they admit a child or employee with AIDS. Even if they are convinced the students or employees can be admitted safely, they often can't persuade their communities.

"Although most of the state health departments and local health departments who are advising the schools are pretty much following our guidelines . . . most of those making the decisions are local school boards," said Dr. Martha Rogers, an epidemiologist who heads CDC's pediatric AIDS unit.

Local school boards "pretty much bend to public pressure. They're knowledgeable about the medical information, but the public really rules. Many times policies get developed that don't let children in schools." —Dr. Martha Rogers, epidemiologist, pediatric AIDS unit, U.S. Centers for Disease Control

Local school boards, she said, "pretty much bend to public pressure. They're knowledgeable about the medical information, but the public really rules. Many times policies get developed that don't let children in schools. You may have a public health service repeating our guidelines, but when you get to the local officials who make the decisions, they don't let the children in."

• • •

The fear has gone to such extremes that, in some cases, children who don't have AIDS or the AIDS virus are being kicked out of school because one or both parents have the infection or the disease.

In Ocilla, Ga., the Irwin County Board of Education in March 1986 barred a 6-year-old boy from school after his infant sister died of AIDS. Several weeks later, the board let him back in school, but only if he continued to live with his grandmother instead of his mother, who is an asymptomatic carrier of AIDS.

When her infant died, the mother, whose name has not been released, voluntarily removed her son from school pending the results of an AIDS antibody test, according to Dr. Keith Sikes, chief epidemiologist for the Georgia Department of Human Resources and vice chairman of the state AIDS Task Force.

When his test came back negative, "the child still was not allowed back in school," Sikes said. Sikes then went down to

talk with the school board, and persuaded them that no medical reason existed to keep the boy out of school. "I saw no reason why he couldn't live with his mother," Sikes said, but "that's not a public health issue, it's a social and political issue," so he was powerless to affect the boy's living situation.

Ocilla Superintendent Rudene Gentry said that as soon as the board learned about the situation, they sought legal and medical advice "because it was certainly new to us. All we had to go on was what we read in the newspaper and see on television programs. Everything we heard sounded scary."

"All we had to go on was what we read in the newspaper and see on television programs. Everything we heard sounded scary."

—Rudene Gentry, superintendent, Irwin County Board of Education, Ocilla, Ga.

Gentry said he had a hard time just finding an AIDS expert. "Finally, we got transferred to Dr. Sikes, I don't know why we didn't know about him, but being a small rural school and not knowing it was going to hit us, we hadn't sought out any help. We've been busy building a new school and so forth."

Sikes's visit, which included a seminar for school officials and some parents, "did help to eliminate a lot of the fear that we had," Gentry said. "It didn't totally eliminate all the fears, I don't think anything will do that until we get a vaccine and are sure the disease won't spread."

Gentry said the school board did not force the mother to live apart from her child. "The mother indicated her willingness to continue that arrangement. She felt like, and we agreed with this, it would help alleviate the fears of other parents, that this child would be living with the grandparent."

Fear, said Sikes, "caused the situation." Ocilla is a small town of 1,500 people, in which not only the woman's infant, but two of her neighbors had died of AIDS, he said. The three women apparently got the AIDS virus from intravenous drug use, and the infant was infected at birth, he said.

Even though there is an explanation for the infections, the impression exists of a disease spreading through a neighborhood, and that's gotten the town "very scared and unsure of what's going on," Sikes said. In a town the size of Ocilla, three deaths

from AIDS send as many shock waves through the community as do the thousands of AIDS-related deaths in New York City, he said.

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The community of Kokomo, in the heart of rural Indiana, is the home of the most celebrated AIDS-in-the-schools case. Ryan White, a 14-year-old junior high school student with hemophilia and AIDS, has been bounced in and out of the Western School Corp. for the past year and a half.

Superintendent James O. Smith, while he made his decision to bar White from school a month before the CDC guidelines came out, says he might very well make the same decision today.

"I'm not certain. The problem is the uncertainty of the information," Smith said. "The people who are in CDC and the Indiana Department of Health want to make decisions on the basis of data. Of course every day, every month, there are more data. I'm not so certain right now if the data are supportive of their position or mine."

"The problem is the uncertainty of the information. ... Every day, every month, there are more data. I'm not so certain right now if the data are supportive of their position or mine." ***—James O. Smith, superintendent, Western School Corp., Kokomo, Ind.***

Smith said he was forced to make his decision with no help from public health officials. "We had been waiting for months to get a decision from the state board of health, and they hadn't done anything yet. When you'd ask them, they'd say, 'Well, we're working on it.' That gives you a message immediately. You don't know what to do. So there was that period of uncertainty, timidity, lack of position on their part," Smith said. "Now, of course, since we made the decision, it seems those people are very strong in their position."

Dr. Woodrow Myers Jr., Indiana state health commissioner, said his office began to work on a position as soon as he became aware a child in Indiana had AIDS. Myers said the state health department released its position, which is similar to CDC's, in July 1985, but he was unable to persuade school officials to adopt that stance.

"It is very difficult to convince individuals who aren't in the mood to be convinced regarding scientific information," Myers said. "What the public wants is what I am not prepared to give: a 100 percent ironclad guarantee that nothing will happen to their child. I never could [give such a guarantee on any other issue], and why should we start now? So there's always the notion in the public that health departments, CDC are hiding something."

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A major problem is that while public health officials are quite firm in their position, they haven't effectively gotten the word out. It's not just school officials in rural communities who are confused; national education associations also are unsure how to advise their members about AIDS.

"What the public wants is what I am not prepared to give: a 100 percent ironclad guarantee that nothing will happen to their child."
—Dr. Woodrow Myers Jr., state health commissioner, Indiana

Scott Thomson, executive director of the National Association of Secondary School Principals (NASSP), said, "I frankly don't know" if students with AIDS should be admitted "because medical authorities disagree. If we're not confident that the majority of students are safe, then we should be careful, we should try to protect the majority of students by being very cautious about admitting AIDS students." NASSP does not have a policy on AIDS because there is so much confusion, Thomson said.

If a school employee contracted AIDS, Thomson said, he would "put the person on a leave of absence until I got a written and signed statement from a medical authority that it was safe for this person to instruct in school."

Gary Marx, spokesman for the American Association of School Administrators (AASA), said administrators have "a couple of real conflicts."

"Whenever anything is in doubt, the fear level tends to grow, and administrators need to deal with that," Marx said. "If people are concerned that AIDS can spread in ways that have not been published, then the fear level goes up, and administrators need to deal with it. The other point of conflict is in the area of student rights, individual rights I should say, versus

public health. A lot of administrators feel very strongly about the individual rights of students. On the other hand, they have to deal with the public health issue. That's a very difficult issue."

AASA, however, does not believe its role is to tell administrators how they should resolve such conflicts. AASA Executive Director Richard Miller said the organization has "no formal policy on AIDS, because we believe strongly in local control. Each community must establish its own policy."

Similarly, the Council of Chief State School Officers (CCSSO) and the National Association of State Boards of Education (NASBE) are leaving the issue to the states. "We have not tried or even considered an organizational policy," said William Pierce, CCSSO executive director. "Each state is handling it in ways that they feel are appropriate. Some of the states are not making any kind of state policy, they're leaving it up to local districts."

"If we're not confident that the majority of students are safe, then we should be careful, we should try to protect the majority of students by being very cautious about admitting AIDS students." —Scott Thomson, executive director, National Association of Secondary School Principals

Phyllis Blaunstein, executive director of NASBE, said her organization does not intend to recommend a policy to its members. "It appears the medical profession does not have its act together at all," she said.

A few national education groups have issued policies on the AIDS issue. But with the exception of the two teacher unions, the policies basically encourage schools to come up with their own guidelines.

The National Association of Independent Schools (NAIS), for instance, calls on its 1,000 member schools to "establish policies and procedures to deal with the victims of AIDS on a case-by-case basis before such action is necessary." (See Appendix E for full text of NAIS statement on AIDS.) The National Association of Elementary School Principals, when asked for its policy on AIDS, provided a three-paragraph policy on communicable diseases that urges health agencies to retain responsibility for controlling disease.

The National Education Association (NEA) and the American Federation of Teachers (AFT), on the other hand, have come out with extensive guidelines (reprinted in full in Appendices C and D) that emphasize the due process rights of employees and students with AIDS, as well as other employees.

NEA would go along with schools' requiring students or employees to undergo a medical evaluation if "reasonable cause" exists.

The NEA guidelines, like CDC's, state that schools should make decisions on students and employees with AIDS on a case-by-case basis, using a team approach similar to CDC's.

NEA would go along with schools' requiring students or employees to undergo a medical evaluation if "reasonable cause" exists. As an example of reasonable cause, NEA cites cases where the employee's spouse has AIDS or the employee recently gave birth to a child with AIDS. A student or employee's sexual orientation, on the other hand, would not be reasonable cause and NEA believes no student, employee or potential employee should be required to provide information on his or her sexual orientation.

If an AIDS-infected student is not allowed to attend classes, schools should not require employees to work with the student, say the NEA guidelines. Instead, volunteers should be used to provide the student "with an adequate alternative education." If employment of an AIDS-infected school employee is discontinued, NEA calls for the school employee to use any available medical leave and medical disability benefits.

The AFT policy statement suggests schools start with the CDC guidelines and use the AFT statement as a supplement. Like the NEA and CDC guidelines, AFT recommends case-by-case decisionmaking. It also suggests districts provide an appeals mechanism for parents and employees who disagree with placement decisions.

AFT calls for alternative instruction for children not allowed in school and medical disability retirement or comparable compensation, including continuation of health insurance coverage, for employees who are unable to remain on the job.

AFT recommends against mandatory employee or student screening for AIDS, based on current medical research. And it

calls on schools to provide students and employees with education about contagious diseases.

> ***"We're trying to keep it from being the kind of issue that evokes hysteria."*** ***—Scott Widmeyer, spokesman, American Federation of Teachers***

"It hasn't been a major issue," said AFT spokesman Scott Widmeyer. "We're trying to desensationalize the whole thing. We're trying to keep it from being the kind of issue that evokes hysteria. It hasn't reached that stage. We would certainly like to keep that from happening."

Agreed Michael Simpson, an attorney in NEA's general counsel's office, "We haven't had very much contact with the states on this."

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It's clear that decisions about AIDS in the schools are largely a state, and even more so, a local issue. At least 17 states, and dozens of local school districts, have AIDS-in-the-schools policies. And the numbers are going up constantly.

In most states, existing law deals with some of the situations that come up in AIDS cases. Grace Belsches-Simmons, an attorney with the Education Commission of the States, found that 46 states exclude pupils from regular school attendance because of illness, 17 states include chronic illness as a condition entitling children to special education, and 25 states exclude chronically ill personnel from contact with children.

• • •

Review of more than two dozen state and district policies shows that most jurisdictions that have AIDS policies based them on the CDC guidelines. Here is a sampling of the policies on AIDS:

■ Connecticut State Department of Education (reprinted in full in Appendix F): "As a general rule, a child with AIDS/ARC should be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges and services provided by law and local policy of each school district."

WHO GETS AIDS?
The majority of all AIDS cases have occurred among the following people:
HOMOSEXUAL AND BISEXUAL MEN
- about 73% of reported AIDS cases - who risk contracting AIDS through sexual activity. Especially at risk are those with many sexual partners.
INTRAVENOUS DRUG ABUSERS
- about 17% of the reported cases - who may have been exposed to AIDS by sharing contaminated needles.
HEMOPHILIACS AND PEOPLE WHO HAVE HAD BLOOD TRANSFUSIONS
- about 2% of the reported cases - who apparently contracted AIDS through the use of donated blood or blood products.
HETEROSEXUALS
- who have been sexual partners of AIDS patients or other persons in the risk groups - about 1% of the reported cases.
So--
SEPARATE THE FACTS FROM THE FICTION ABOUT AIDS!
Do your part in the fight against AIDS.
✓ KNOW THE FACTS about AIDS -- new information being discovered and what's being done to stop it.
✓ SUPPORT EFFORTS to find treatments.
And, put your knowledge and understanding to work by
DISPELLING THE MYTHS AND FEARS ABOUT AIDS TODAY!

Source: School District of Philadelphia

Figure 6

Reprint From The Philadelphia School District's AIDS Fact Booklet

BEST COPY AVAILABLE

■ Philadelphia Board of Education (reprinted in full in Appendix G): Students or employees with AIDS will be admitted to the classroom after approval by a screening committee. In addition, Philadelphia is one of many school districts and states to come up with its own pamphlet on AIDS (see Figure 6).

■ Maryland State Department of Health and Mental Hygiene: Decisions will be made on a case-by-case basis "taking into account the child's behavior, neurologic development, and physical condition." Most children should be admitted to school.

■ Ohio Department of Health: "Children with AIDS should be allowed to attend school in a regular classroom setting provided" their health permits participation in regular school activities, they behave acceptably, and they do not have open sores that cannot be covered.

■ Missouri State Board of Education: The CDC guidelines are "a good standard for dealing with this serious problem. . . . The local board of education of each school district in determining how it will deal with this issue should ensure the least restrictive environment for each child involved."

■ Wyoming Department of Health and Social Services: A panel in the school should evaluate each case individually. If a decision is made to exclude the child from school, the local school board will be responsible for providing alternate instruction.

■ Des Moines Public Schools: Children with AIDS "may attend classes in an unrestricted educational setting," unless they have open sores, inappropriate behavior or are too ill to attend.

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While a growing minority of states and schools are coming up with their own AIDS policies, few have faced the situation of having to deal with a student or employee with AIDS. What happens in the real world when a child or employee appears at your schoolhouse door with AIDS? Chapter Three discusses how two school districts faced the situation and came out with wildly differing public reactions.

Chapter Three

How Two School Systems Reacted To An AIDS Crisis

CASE STUDY: NEW YORK CITY

Act in haste, repent at leisure. That's how many education-watchers describe the furor that erupted when New York City officials, two days before school was to start in September 1985, announced that a second grader with AIDS would be attending school somewhere in the city.

Telling parents and teachers that "somewhere" in New York City—with nearly 950,000 schoolchildren spread out over 968 schools in five boroughs—was a child with a contagious disease was tantamount to yelling fire in a crowded theatre. Panic ensued. Every parent was sure the child with AIDS would be sitting next to their child. Every teacher was sure the child would be in their classroom. And the thing was, they just wouldn't know.

First, a little background. New York City has the highest concentration of reported cases of AIDS in the country. At the time this controversy started, 4,531 persons with AIDS had been reported in New York City, of which 52 percent, or 2,354, had died. Of the reported cases, 82 were children under the age of 13, of which 68 percent, or 56, had died. At the same time, it was estimated that in New York City 350,000 to 400,000 persons were asymptomatic carriers of AIDS, including up to 2,000 youths age 5 to 18.

In a community with such a high awareness of the devastation AIDS can bring, it should have come as no surprise that the reaction would be swift, and sure. But surprise it did. School and health officials were totally taken aback at the public hysteria.

More than 11,000 students boycotted school in two districts in Queens. Of 27,000 elementary and junior high students in 35 schools in District 27 in southwest Queens, 7,000 stayed home.

In nearby District 29 in eastern Queens, 5,000 elementary and intermediate students out of 20,000 in 28 schools stayed home.

And the local districts went to court to keep the child out of school. That court battle, and Judge Harold Hyman's decision upholding New York's policy to allow children with AIDS to attend school on a case-by-case basis, is analyzed in Chapter Four. But no description of how New York City has dealt with AIDS would be complete without touching on the circus atmosphere surrounding the trial. The judge himself, in *District 27 v. Board of Education* (the full text of the decision appears in Appendix H), described the scene in New York City:

> [T]his singular court proceeding became the immediate focus of intense public interest and media attention, involving as it did highly emotional and controversial questions of civil rights, confidentiality, government, and school-aged children touched by one of the most publicized lethal infectious killers known to modern medicine.

Even though the city won the case, the judge went out of his way to chastise the way the school officials had handled things:

> The portrayal of parents as misanthropes because they disagree with respondents is unjustified. It is unfortunate that the petitioners and their constituents chose to use children on the picket lines and as part of a boycott. This conduct, however, is not unique in this society. In the ultimate, the conduct of the petitioners and their constituents disprove the mistaken notion of the respondents that the people cannot be trusted with the information they need to know to make reasonable decisions.
>
> One would have thought that the time had long passed when public officials would exhibit such insensitivity. Instead of educating and inspiring the confidence and trust of the public, respondents left them frustrated and hostile in the face of such an emotionally charged issue. It is these public officials themselves who predictably, although perhaps unwittingly, let loose the forces of anxiety and fear. Blame is to be borne as well by certain members of the medical community who by their professionally irresponsible and baseless characterizations of this disease as a 'plague' only exacerbated the fears that fueled the passions. Where the issue was so compelling and the stakes

nothing less than our progeny, the public should have been informed.

City officials were overjoyed to have won the case, but defended themselves against the criticism. "We believe the city education officials did the best they could under the circumstances," said Frederick Schaffer, an attorney with the New York City corporation counsel. "We certainly recognize that had the timing been otherwise, it would have been advisable to do more to educate the public and involve the public more. It was regrettable that was not possible."

"We believe the city education officials did the best they could under the circumstances."
—Frederick Schaffer, attorney, New York City corporation counsel

But it was possible, says Robert Sullivan, attorney for the two suing school districts. "Here's what they should have done. First of all, they should have held public hearings. Second of all, they should have educated the teachers and equipped them to handle it and implemented safety precautions. And here's the most important thing: regardless of which decision you're going to make, you have to make your decision in June, two months before school starts."

New York's biggest mistake, Sullivan said, was to wait until 36 hours before school started and then make the announcement. "What happened was it caused a panic. But they caused the panic."

Sullivan said school officials had enough information to make, and announce, the decision in June. "We could have had the court action then, the public could have reacted, teachers could have been educated. They also would have had time to implement safety precautions. They just said a kid with AIDS is coming and that's it. That's where their big mistake was."

School officials reacted to the accusation that they moved slowly by providing a written chronology of their activities relating to AIDS. The chronology states that school officials chose to wait until August to make the announcement so they would have the benefit of the latest scientific information, so health and board of education staff would have time to work together on the guidelines, and so teachers would hear about the guidelines at work rather than from the media.

To Sheila Gutter, a teacher in New York City, the worst part was not knowing which child had AIDS. "It's important we know who has AIDS to prevent what happened in Queens [from happening elsewhere]. The attitude was, 'We will not tell you, but not to worry.' I think that's a loaded deck. It's unfair. I believe the child has to be identified to people directly involved with the child. If a child has a nosebleed or regurgitates, the teacher has to know. Most of my colleagues agree."

• • •

The city thought it was doing the right thing, said Bruce Schutte, senior public health educator in the AIDS unit of the city health department's Bureau of Public Health Education. But the timing didn't work out very well.

New York City officials "just said a kid with AIDS is coming and that's it. That's where their big mistake was." —*Robert Sullivan, attorney, New York City*

"The Department of Health and the Board of Education decided a policy was needed on what would happen if the family of a child with AIDS wanted to register the child into the schools," Schutte said.

Under the policy, adopted in August 1985, children diagnosed as having AIDS are screened by a multidisciplinary panel made up of a pediatrician, a medical social worker and representatives of the Board of Education and the PTA.

"If the panel decided it was appropriate for this child, in terms of his health and developmental skills, to be in a school setting, the child would be allowed to attend school," said Schutte. The presumption was, as in the CDC guidelines, that because AIDS does not spread by casual contact, children should be admitted as long as their behavior was under control and they did not have open lesions. "A child who is basically intact and in control of bodily functions and behavior would be reviewed and if healthy enough would be allowed to attend," Schutte said.

Under this panel, a group of children was screened before the 1985-86 school year began and it was determined that one could attend school. "That's when the parents in Queens became very upset and decided to boycott school," said Schutte.

Let's move about half a year down the road, to May 1986.

The New York City lawsuit is over and there are no plans to appeal. The original child was found not to meet the definition of clinical AIDS and remains in school. And the panel, its deliberations approved by the court, continues to screen children with AIDS.

Students "want to know what kind of sexual practices are more likely to spread AIDS than others. . . . It's not something they take lightly."
—Howard Welsh, field monitor, Gay Men's Health Crisis, New York City

The controversy has not gone away, but it has dimmed, and that's in large part thanks to the efforts of city officials, especially health and education officials, who moved quickly to educate teachers and students.

The Department of Health trained a corps of its employees, physicians and health educators to go into the schools and address teachers and PTAs on AIDS.

"When the hysteria first hit, parents and teachers were . . . not very receptive to our message," Schutte said. During most of September and October, "people were not assimilating the message very well. It seemed as though their emotions really took over. . . . There was a lot of mistrust."

In those first couple of months, the major concern was transmission. "Certainly it was the fear, 'Can I get it? Can my child get it?'" Schutte said. In the following six months, "there has been a gradual shift. People still are concerned about casual contact, but they are more aware that casual contact is not a risk. People are more willing to talk about some of the underlying issues, to talk about homophobia, to talk about civil rights."

Health department officials also prepared two videotapes on AIDS that featured prominent physicians in the AIDS field and teachers quizzing the experts on AIDS. The Board of Education sent all students home early one day in late 1985 so employees could watch the videos, which were simulcast to every school in New York City.

And health officials helped the school district rewrite its first aid instructions to better enable employees to deal with children with AIDS; employees are to use the instructions to deal with a bleeding injury in any child (see Figure 7).

Figure 7
New York City School District's First Aid Instructions
October 1985

Condition	Instructions
Animal or *Human Bites*	Wash thoroughly with soap and water *to remove saliva.* Cleanse with alcohol swab. Dry and cover with gauze. Notify principal to refer for further treatment if necessary.
• • • • •	
Bleeding	Use direct pressure to control bleeding. Apply pressure bandage. If bleeding continues, notify principal to call ambulance. *Blood that gets on surfaces such as desks or floors should be cleaned with soap and water. This may be followed by disinfection with rubbing alcohol or household bleach diluted with water. There should be ten parts of water and one part bleach if it is used.*
• • • • •	
Nosebleeds	Have child sit with head tilted forward, breathing through the mouth and spitting blood into a container, rather than swallowing it. Loosen clothing around neck. If these measures do not stop bleeding, notify principal. *Blood that gets on surfaces such as desks or floors should be cleaned with soap and water. This may be followed by disinfection with rubbing alcohol or household bleach diluted with water. There should be ten parts of water and one part bleach if it is used.*

Note: Italics reflect amendments in the chart to deal with the presence of AIDS-infected children in the classroom.

Source: New York City Department of Health

The next step was educating the students. Board of Education curriculum staff wrote two lessons on AIDS for junior high and high school family living courses, and health department staff provided training.

Principals selected more than 500 teachers to go through an intensive three-hour in-service training course. Most "were either selected because they were already doing sex education in the school and could handle sensitive issues or they had volunteered," Schutte said. The teachers ranged from physical education instructors who teach one or two health classes, a group Schutte terms "much less effectual" than those at the other range of the spectrum, trained health educators. Guidance counselors and some administrators also attended.

The variety of disciplines was good "so there would be many perspectives, and each school could decide how to teach the class," Schutte said. For instance, a guidance counselor and a health teacher might decide to teach a class together. A benefit to team teaching is to minimize the amount of bias that might enter into the discussion, he said.

"I believe the child has to be identified to people directly involved with the child. If a child has a nosebleed or regurgitates, the teacher has to know. Most of my colleagues agree." ***—Sheila Gutter, teacher, New York City***

The health department, however, is not recommending any particular approach, instead saying that "when you leave our class, you need to meet and decide the most effective way to teach." A strong recommendation, however, is to teach the curriculum in a regular class, not "with 100 kids in an auditorium."

The concept behind the curriculum is that sexual health care is the responsibility of each individual and that sexual health care requires responsibility to "oneself, one's family and society," according to a copy of the curriculum.

Both the junior and senior high lessons explain how the disease is transmitted and who is most likely to get AIDS. The high school lessons go into more detail on transmission, discussing, for instance, the dangers of anal intercourse with an infected person. Each curriculum is designed to be personalized by a teacher and his or her students. "The family learning curriculum is just strategy without complete lesson plans because it

is designed to be unique in each community," said Geri Abelson, who designed the curriculum for the Board of Education.

> ***"When the hysteria first hit, parents and teachers were not very receptive to our message. It seemed as though their emotions took over. There was a lot of mistrust. —Bruce Schutte, senior public health officer, New York City Bureau of Public Health***

The Board of Education got no opposition from the community to including AIDS in the family living curriculum, Abelson said. Parents do have the opportunity to veto their child's taking the course. "A letter goes out to parents saying the education will be offered. If they don't want their child to have it, they can sign a note, and the child will not get into a class," Abelson said.

Because of New York City's political structure, the Board of Education was able to mandate the curriculum to junior high schools, but only "instruct" the high schools to teach it because of local district control, said Abelson. Family living courses have been offered in New York City schools for 20 years, but, again, not in every district.

Schutte is not sure two lessons on AIDS are sufficient, although he admits it would be hard to fit any more into the curriculum. "But when you get talking on this issue, people can spend a lot of time talking about their feelings. . . . The curriculum has a lot of information in it but the constraints may be that there is not enough time to process students' feelings."

Abelson said she believes two lessons are sufficient because the Board of Education has "structured a support system for any child who has further worries." First, students are given a list of resources, including hotlines they can call for further information. Second, the teachers are trained to provide further guidance and counseling.

Despite all their efforts, the boards of health and education haven't convinced everyone. Sullivan, attorney for the two suing school districts, gives a split rating to the training programs: "The education to the high school students is very good, the education to the grade school students isn't bad, but education to the public in general and to the teachers is somewhat lacking."

The Gay Men's Health Crisis in New York City, which has taken the lead in AIDS education for the gay community nationwide, has praise for New York's education efforts.

While school officials in other cities may be hesitant to include explicit language in AIDS courses, "in New York, where hysteria has run very high, quite the opposite has been the case," said Howard Welsh, a field monitor in the organization's education division.

His group also is invited into schools to speak and finds that "students concern themselves with personal transmissibility, the risk to themselves. They want to know what kind of sexual practices are more likely to spread AIDS than others. There is a great deal of understanding. Most of the students understand it in terms of a life and death issue. It's not something they take lightly."

Parents have the opportunity to veto their child's taking the course. "A letter goes out to parents saying the education will be offered. If they don't want their child to have it, they can sign a note, and the child will not get into a class." —Geri Abelson, curriculum specialist, New York City Board of Education

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The crisis in New York, as in most cities, centered around a student with AIDS. But during the trial, controversy erupted over an employee who had died of AIDS.

"At the same time we were in the beginning stages of the school trial, there was also huge media attention given to the fact that a dietician in one of the schools had died of AIDS," said Schutte. "That was a big thing, just something that further fed the whole trial."

But the health department's position, like CDC's, is that any person with AIDS in the work force, including in schools, "would not be a threat to other individuals as far as transmission, because transmission takes place with sex or IV drug use. It doesn't matter if you work with food or machinery."

The school board's policy on employees is basically the same as its policy on students, where decisions are made on a case-by-

case basis, said board spokesman Robert Terte. Because "no screening of employees is done, presumably if somebody has the virus or even AIDS, if they were able to function, we would not necessarily know they have the disease."

> ***"Forthright conduct by public officials should avoid much of the distress and acrimony" that surfaced in New York City.***
>
> ***—Judge Harold Hyman, Queens County Supreme Court***

The only information the school board would have on employees with AIDS would be if they ask for medical leave. "A determination could be made that the reason for their absence could be AIDS based on the symptoms presented," Terte said. Right now, the board doesn't "have any indication of anybody working in the system with AIDS." Typically, the board would get "reports after the fact, rumors of somebody who had been employed that died of AIDS."

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Most observers agree the problem in New York is that the decision was made in secret. Teachers and parents were not consulted, and the announcement came as a major surprise to anyone lower than top administrators.

The lesson for other schools?

- Come up with a policy before you have a problem. When Sullivan advises other school districts on the issue—and he's been much in demand since the New York case—he tells them to make the decision early. "I tell people, I don't care what position you take, do it in June, don't wait until September, so people will have time to adjust to it."
- Inform the public about AIDS. The five-week trial in New York could have been avoided "had the public officials involved trusted the people," Judge Hyman wrote. The court was forced to "fill the educational void by surfacing information which should have been provided to the public as a matter of routine." Hyman acknowledged that even if administrators had been more open, the public still might have disagreed with their decision. But "forthright conduct by public officials should avoid much of the distress and acrimony which has surrounded this litigation."

■ Train your teachers to deal with AIDS in the curriculum. While no trainer gets guaranteed success, the training has helped calm down the situation, according to Schutte. "In terms of making changes in behavior, changes in attitude, having people believe the information, I certainly do believe person-to-person contact is much more successful," he said.

■ And finally, learn from New York's mistakes. "If New York City could play the tape over, there is no question we would do it in a more efficient way. The reality is you have to make decisions at a certain point in time," said Dr. Louis Cooper, director of pediatric service for St. Lukes-Roosevelt Hospital Center in New York City. "There is no reason other communities have to go over the same bumps we did," said Cooper, who was an expert witness in the New York City court case.

CASE STUDY: SWANSEA, MASS.

It would be nice if for every horror story about AIDS in the schools, there were a success story to balance it off.

Well, there isn't, but there is one story that should give heart to school administrators looking with trepidation to the day they may have to deal with a student or employee with AIDS.

That tale involves citizens of the southeastern Massachusetts town of Swansea (population 15,000), who rallied behind a Case Junior High school student with hemophilia who caught AIDS from contaminated blood products.

It began in late summer 1985 when Dr. Peter S. Smith, director of the Hemophilia Clinic at Rhode Island Hospital, told Swansea school officials that one of his patients—a 13-year-old student at Case—had contracted AIDS.

The timing, as in New York City, was terrible. "It was Mother Nature. AIDS struck him during the summer," said Smith.

School officials found out that Mark (his last name has not been revealed publicly, although everyone in Swansea knows who he is) had AIDS only one week before school was to start. By the time Smith was able to get together with Swansea Superintendent John McCarthy and Case Principal Harold Devine Jr., it was the day before school was to open.

But in that one short week, McCarthy leapt into action. He contacted the U.S. Centers for Disease Control and got advance word on their upcoming AIDS guidelines for schools (reprinted in Appendix A). He contacted the Massachusetts departments of Education and Public Health and got their advance words on soon-to-be-published guidelines. He got a copy of the already-published Connecticut AIDS guidelines (see Appendix F). He also got a legal opinion from the Massachusetts state education department.

Thus armed, McCarthy made his decision. All of the guidelines "essentially say the same thing, ... that the public health people and the attending physician determine whether or not there is a threat to the other children. If they determine there is not, the child has a right to be in school," McCarthy said. "It's my duty as superintendent to protect that right. Now, saying that and doing it are two different things."

The timing was terrible. School officials found out Mark had AIDS only one week before school was to start.

Here's how it was done.

First, McCarthy, Devine and Mark's teachers attended the day-before-school meeting with Dr. Smith and his team of a pediatric nurse and a social worker.

"I had all the teachers who would be directly working with the student with me and they had an opportunity to ask every question they could possibly think of," said Devine.

Based on his prior research and the information Dr. Smith's team provided, McCarthy decided that day that Mark should be permitted to attend school.

The next day, classes began at the 653-student Case Junior High and the rest of the 3,000-student district. Toward the end of the first week, Devine called Smith and his team back to Case to meet with the rest of the 50-member faculty. "We were very concerned with confidentiality and limiting the numbers of people who knew, but I felt those teachers needed to know," Devine said. "When we dealt with the entire faculty, the first group of teachers [Mark's teachers, who had attended the first meeting] was very supportive of the child's right to remain in school. This was extremely helpful in working with other faculty."

At this point, Mark's condition still was not public

knowledge. "That's very important. By the time it became a public issue, the second week of school, the teachers were behind the decision—not unanimously, but as a group, they were behind the decision—and when the situation did become public, we had the children in school and we were able to deal with the major educational issues during that day with the students," Devine said. "All the teachers were very well versed in the issues so it didn't matter which class the questions arose in. All teachers were prepared to deal with it." Case Junior High's students are in grades six, seven and eight.

The situation became public through an article in a local weekly newspaper. Major media outlets—print and television—quickly picked up the story. None named Mark.

The situation became public through an article in a local weekly newspaper. Major media outlets quickly picked up the story. None named Mark.

"At the end of the first day it became public, the children went home, and in hindsight I think something very special happened," Devine said. "I think to a large extent, the children reassured their parents as to the realities of the situation. The children were secure in their knowledge of what was going on. They played a large role in stemming the fear that the parents were naturally going to exhibit."

To allay the fears, school officials scheduled a meeting with parents one week from the day the newspaper story broke. "We needed the time. During that time, we used every opportunity to present factual information to the media," Devine said. Also during the week, Devine was "getting calls from parents who were greatly concerned. They wanted to know, 'Why are you doing this?' and 'How can you do this to us?' My response to all of the parents was to invite them to call their pediatrician, their family physician, to refer medical questions to authorities you have faith in."

The information-gathering week passed, and some 700 parents and other community people filled the Swansea High School auditorium for the meeting with school officials, Dr. Smith and his team, and a state epidemiologist.

"We went over the entire issue, the rationale behind our decision," said McCarthy. "We weren't there to vote, to discuss it. We said, 'This is what we did.' The people took up the thing and

said, 'Doggone it, they're right.' The support was overwhelming."

One woman at the school meeting that night started a petition to keep Mark out of school. She stood in the town baseball field—a central location in Swansea—for three nights and only gathered 43 signatures, of which about half were invalid because they were not from Swansea residents.

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Another of the parents at the meeting was Sue Travers, a telephone company employee with a son at Case Junior High. Because she works full-time, Travers had never gotten involved much in local politics. But when she heard about the meeting, she spoke with other parents and "found people really concerned. They were really fearful for their children, they wanted to know what to do."

"The children reassured their parents. . . . They played a large role in stemming the fear that the parents were naturally going to exhibit."
—Harold Devine Jr., principal, Case Junior High School, Swansea, Mass.

Travers decided to attend the meeting. When she got there, Travers was impressed by Superintendent McCarthy's fortitude in sticking to his position to keep Mark in school. "I really have to say, he never led anyone to believe a petition of any sort would sway his decision. He said, 'I have made my decision. This is the right thing to do.' He never backed down. He earned my respect that night."

After the presentation, the questions started flying from parents fearing for their children's health. What if that kid spits on my kid? What if they get into a fight on the playground? Won't they catch AIDS?

"I finally said to my husband, we can't let that go on," Travers said. "I stood up and said if all that is true, we ought to then shut down churches, health clubs, supermarkets, because who knows who had been cutting meat in the butcher shop, everyone would have AIDS. The bottom line is this is a little kid. We have to be compassionate to this family. After that, other people stood up and were vocal."

Travers didn't know Mark or his immediate family at the time

but, after the meeting, Mark's uncle called to thank Travers for her support and to let her know Mark was back in the hospital because of all the stress. "I said, 'What can I do? What if we make a meal and send it over?'"

The meal was made, and from that small beginning Travers organized the Friends of Mark, which has raised $10,000 to help with Mark's medical expenses.

Travers started out with three mothers and the group grew to 30. The group prepared a different meal every night for a month for Mark's family. They ran a raffle that made $5,000. They held a dance that raised $1,000.

> ***"The bottom line is this is a little kid. We have to be compassionate to this family."*** ***—Sue Travers, parent, Swansea, Mass.***

"People really supported us and backed us. People were really tripping over themselves, saying, 'I want to help, I want to help.' It was a crazy month. When they [Mark's family] started seeing all this stuff, they were just overwhelmed. He made a wonderful recovery."

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The result of all this, according to people in the community, is that Mark has remained in school (except for the brief spell when he was hospitalized), and everyone treats him like the normal kid that he is. And, of course, no one has contracted AIDS from Mark.

"If you were to see that school operate today, it's like any other middle school, no different. He's one of the kids, no different," said McCarthy. "From day one, the kids were extremely supportive."

Principal Devine agrees. "The most gratifying thing is the attitudes that have been formed by the students," he said. "They have accepted him as one of their classmates who wishes to have a normal classroom experience. They think that's very important. One of the tenets of that is we don't treat him any differently. When you're walking down the corridor, you don't see people cringing against the wall. There's not even a hint of that."

The proof that things have worked out, in Travers's view, is

Principal Devine agrees. "The most gratifying thing is the attitudes that have been formed by the students," he said. "They have accepted him as one of their classmates who wishes to have a normal classroom experience. They think that's very important. One of the tenets of that is we don't treat him any differently. When you're walking down the corridor, you don't see people cringing against the wall. There's not even a hint of that."

The proof that things have worked out, in Travers's view, is that "life is back to relative obscurity."

"We're right back to where we started," she said. "He's a straight-A student, they don't treat him like a celebrity. . . . The attendance levels are fine, there are no more petitions." Part of that return to obscurity is a reluctance on the part of Mark and his family to be interviewed; they were not approached for this report.

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People in Swansea, Mass., don't claim to be different than people in Kokomo, Ind., or New York City. But their reaction to the announcement of Mark's condition varied dramatically from the better-publicized outcry in the other two cities.

"If you take a look at the young man from Indiana, my kid looks just like him. In fact, I look like the superintendent. The difference is, nobody knows my kid's name. Everybody knows Ryan White."
—John McCarthy, superintendent, Swansea, Mass., public schools

"It was a fantastic success story, considering how things could have gone," said Dr. Peter Smith, Mark's doctor. "It was a struggle, but it worked out very nicely."

Smith said the right mix of ingredients helped resolve the situation: "We all worked together, we didn't have our own ax to grind. We figured here's a problem, we couldn't just go hush it up and pretend this kid did not have something and sneak him into the school. We decided to work together as a team. I think everyone did their homework and did it very nicely."

Another key ingredient was that Mark had advocates outside his family, something other children with AIDS often lack. "My gut feeling is they [children in Indiana and New York] didn't have advocates," Smith said. "We have a long tradition in the

Hemophilia Program of being advocates. I've gone to schools for other things. My nurse coordinator routinely goes out to allay fears about hemophilia, fears about getting hurt. That's been our mission, among other things."

And Mark had advocates in his superintendent, his principal, and parents like Sue Travers. "I'm in constant contact with Kokomo, Ind. I talked to Ryan White's mother. The things they are going through are horrendous," Travers said. "Our experience is standing head and shoulders over other communities. . . . No matter who has it, they need a kind word. This is what I don't see happening in Indiana and places like that."

Friends of Mark "wanted to give him a reason to get well. I've been asked, 'Don't you realize he is terminal?' We don't view Mark as terminal, no one is terminal until they're dead. We don't talk to him in terms of terminal, we talk to him in terms of fighting to get well," Travers said.

McCarthy and Devine said in separate interviews that the public support was more than they could have ever hoped for.

"I was pleased," said McCarthy. "When it first started, I didn't know what the reaction would be. I thought this was the right thing to do, but I didn't know what to expect." He said it was hard to pinpoint why Swansea rallied behind Mark. "I'm sure people here are no different than people in Indiana. They're both small town communities," McCarthy said, but he theorized, "I've been in the community a long time, the principal has been in the community a long time. They gave us a chance to talk, and they listened."

The questions started flying from parents fearing for their children's health. What if that kid spits on my kid? What if they get into a fight on the playground?

Devine said that based on what had happened in communities like New York City and Kokomo, "I would have found it difficult to believe this. Knowing the nature of the youngsters, it didn't surprise me, but I had no right to expect that."

Also helping things go smoothly was Mark himself. "This boy Mark is a charming, lovable, active kid, so everyone knew him," said Smith. "The proof of the pudding will be when you have the same thing happen to an unlovable kid."

Devine agreed. "The child had been in the community for some time, he was not a newcomer," his principal said. "The issue we were dealing with was very narrowly defined: a very responsible, intelligent eighth-grade hemophiliac, through no fault of his own, had been given a deadly disease. We didn't have to deal with the usual modes of transmission, we didn't have to deal with the emotions of AIDS victims who have acquired the disease through homosexual activity or sharing of needles.

"Every chance we got, we identified the issue we were dealing with. Parents could easily empathize with the plight of the parents of the victim. What the child wanted was as normal a school experience as possible."

On the other hand, McCarthy noted, it was key not to release Mark's name to the public so he wouldn't feel the intense national media pressure Ryan White has had to deal with. "One of the things I like to contrast this with, if you take a look at the young man from Indiana, my kid looks just like him. In fact, I look like the superintendent. The difference is, nobody knows my kid's name. Everybody knows Ryan White. We fought to protect his name."

• • •

What can other schools learn from Swansea's experience?

■ Do your homework and base your decision on expert medical and legal advice. "Be sure you're familiar with the [CDC] guidelines. When it comes to something like this, you've got to rely on expert decisions," said McCarthy. "Some doctors are not experts, they're all over the lot. We had good expert advice, also good legal advice. Our school attorney was involved."

■ Keep control of the situation. Make an informed decision and stick with it.

■ Talk with the community, but not until you have all your facts in order. Because McCarthy kept control of the situation, he was able to make a decision the day before school opened and let the community know later. But be aware of confidentiality when you do talk with the community. Decide who needs to know the child's identity, and once you decide, don't allow any leaks of information.

■ Appoint a spokesperson. In Swansea, the school board decided that only McCarthy and Devine would be permitted to

speak with the media. "The school committee referred all questions to us. That was a very important thing for them to do because it took politics out of the equation," said Devine. "That was calculated. If you have two spokespersons rather than eight, the possibility of an inconsistent answer is greatly reduced."

■ Consult with your local pediatricians' association. "School districts should aggressively go after the physicians that are caring for their cases and make them get involved," said Smith. "In almost every community there is a chapter of the American Pediatricians Association (see Appendix K for a complete listing). Pediatricians tend to be advocates, to care very much for handicapped children. I think schools should try to identify an individual who is willing to advocate for such children."

• • •

Swansea is practically unique, however. Many school districts have not handled the AIDS issue well, and courts have been called upon to mediate what is usually an emotional issue.

"Now that the legal system is taking over, it's getting better," said Dr. Martha Rogers, head of the pediatric AIDS unit at the U.S. Centers for Disease Control. "I see things sort of coming around a bit."

Chapter Four describes legal action that has occurred so far, analyzes the issues schools and colleges will face in the months and years to come, and tells you how to use the information to protect your school against unnecessary litigation.

AIDS Litigation: Past, Present and Future

Court cases are rarely a pretty sight, but the battles over AIDS have taken on a particularly ugly hue. They have divided communities, destroyed trust in public officials, and cost schools and parents thousands of dollars.

- In New York City, two community school districts in fall 1985 slogged through a five-week trial in a losing fight against the city's policy to admit, on a case-by-case basis, most children infected with AIDS. If the districts' attorneys had not donated their services, the legal costs would have reached $100,000.

- In New Jersey, two school districts in fall 1985 mounted a successful campaign to overturn, on procedural grounds, state guidelines strongly favoring inclusion of children with AIDS in school. The legal work cost $46,000 for one district alone, and the state could end up simply readopting a similar policy in proceedings that comply with state administrative law.

- In the most publicized case to date, a school district in Kokomo, Ind., has been in and out of court since August 1985 over its decision to keep a boy with AIDS out of school. The district originally lost to student Ryan White, but it was immediately sued by parents who, like the school superintendent, wanted the boy in home instruction away from their children.

• • •

AIDS is a legal frontier. Although they received a great deal of publicity, only about half a dozen cases relating to AIDS in the schools were filed in 1985, and lawyers involved in the issue hesitate to guess how many will come in 1986. Some expect a new spate of lawsuits when school resumes in fall 1986. Most of the battles are in state court, and one case is pending as high as the New Jersey Supreme Court. It seems no federal appeals court has addressed the issue, but the U.S. Supreme Court in April 1986 agreed to consider the rights of tuberculosis patients in a

case that may set a precedent for the accommodation of AIDS patients and carriers.

TABLE OF AIDS-RELATED CASES

- Initiated In 1985; Pending As Of May 1986
  Ryan White v. Western School Corp. (86-144), Clinton County, Ind., Circuit Court
- 1985
  District 27 v. Board of Education of the City of New York (14940/85), New York State Supreme Court, Queens County
- Initiated In 1985; Appeal Pending
  Board of Education of the City of Plainfield v. Cooperman (A-1378-85T5), New Jersey Superior Court, Appellate Division, Trenton
- 11th Circuit Ruling 1985; Appeal Pending
  Arline v. Nassau County School Board (772 F.2d 759), certiorari granted (54 USLW 3695)
- 1985
  Shuttleworth v. Broward County Office of Budget and Management Policy (FCHR 85-0624), Florida Commission on Human Relations
- Initiated In 1984; Pending As Of May 1986
  Chadbourne v. Raytheon Corp., California Department of Fair Employment and Housing, Ventura County
- 1986
  Phipps v. Saddleback Valley Unified School District (474981), Orange County, Calif., Superior Court

And AIDS litigation shows no signs of stopping; all indications are that the cases will keep school attorneys on guard—and some quite busy—well into the 1990s. In light of that, school officials and attorneys make the following predictions about how AIDS cases will evolve:

- The most likely statutes AIDS cases will be filed under are Section 504 of the 1973 Rehabilitation Act, the 14th Amendment, the Education for All Handicapped Children Act,

ERRATA

Two paragraphs were inadvertently dropped from the bottom of page 62, *AIDS: Impact on the Schools.*

The section following the Table should read as follows:

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- The most likely statutes AIDS cases will be filed under are Section 504 of the 1973 Rehabilitation Act, the 14th Amendment, the Education for All Handicapped Children Act, P.L. 94-142, state antidiscrimination laws, state special education laws and state communicable disease laws.

- The most likely avenues of success for AIDS plaintiffs will be Section 504 and state antidiscrimination statutes.

- While most of the public debate has been over student attendance, schools are much more likely to be sued over employee issues, such as contractual rights in medical testing, transfers to new assignments and possibly the disability benefits of a teacher with AIDS.

But no suit so far has resulted in a broadly binding precedent. Coast to coast, lawyers are trying to find where AIDS fits into established law in contexts ranging from disability and privacy rights to the right to know of hazards.

The dilemma for schools is that while it appears antibias laws require them to include students and employees with AIDS, mandatory attendance and negligence liability law also require schools to offer students a reasonably safe environment. Some states' contagious disease laws, forbidding students with such diseases to attend school, appear to include AIDS; others, such as New York's, do not include AIDS.

Ryan White v. Western School Corp.

The debate over AIDS in school did not begin in Kokomo, Ind., but Kokomo is where it erupted into litigation.

A boy who unwillingly has come to symbolize the issue, 14-year-old Ryan White, contracted AIDS from contaminated blood products he needs to control his hemophilia. Illness, combined with doubt about the dangers he might pose to other students, kept White out of school for the entire 1985 spring term. By summer, though, the seventh grader was well enough to deliver newspapers, and his mother asked that he be allowed to return to his public school. Western School Corp. refused, and the Whites sued.

A boy who unwillingly has come to symbolize the AIDS issue, 14-year-old Ryan White, contracted AIDS from contaminated blood products he needs to control his hemophilia.

Ryan White's case, still in court as of this writing, has raised a tangle of issues under the Rehabilitation Act, the 14th Amendment, P.L. 94-142, Indiana's special education laws and the state's communicable disease statute.

Some of the rulings in the case have been vague, especially regarding P.L. 94-142, which guarantees handicapped children the right to a free appropriate education in the least restrictive environment possible. To be considered handicapped under P.L. 94-142, a child must need some special education or treatment, but Indiana's special education law defines handicap more broadly.

White's mother in August 1985 filed *White v. Western School*

Corp. (IP 85-1192C) in U.S. district court in Indianapolis, the first of several suits over Ryan's education. Judge James Noland treated Ryan as handicapped under P.L. 94-142, sending the case back for evaluation and placement proceedings, which special education law requires before a case may go to court. But he did so without quoting the law's definitions of handicapped children or stating how it applied to White, who never before had needed special education.

An unpleasant roller coaster ride followed for Ryan and Western. A P.L. 94-142 team placed Ryan in homebound instruction, but a hearing examiner in November 1985 reversed that decision, saying Ryan belonged in a classroom.

> ***"You tell me Ryan White can't 'appear in public.' He's out in restaurants, he goes to the roller-skating rink. Now I'd like to see them put a policeman in his front yard and tell him he can't go out."***
>
> ***—Charles V. Vaughan, White's attorney***

But when the school went to the Indiana Board of Special Education Appeals, that panel based its ruling on state communicable disease law, saying White could attend school if he had a permit from the "appropriate" health officer. White got a permit from the county health official, and it briefly seemed he had won.

White spent just one day back in the classroom, his first in more than a year, when a group calling itself Concerned Citizens and Parents of Children Attending Western School Corp. won a temporary restraining order in state court barring Ryan from the classroom based on another public health law, which says a child with a communicable disease "shall not . . . attend school or appear in public."

The temperature of the already-heated controversy rose even higher. Although his lawyer had claimed victory and although the school was named as a defendant in the new suit, Western Superintendent James O. Smith supported the move to keep White out of school. Speaking several days after the parents won the restraining order, Smith said, "Our position is consistent with what we have done with communicable disease in the past. Indiana law excludes" infected children, he said, although the state had issued guidelines directing schools to admit most students with the AIDS virus.

Charles V. Vaughan, White's lawyer, argued the restraining order was based on a narrow reading of public health law.

"You tell me Ryan White can't 'appear in public,'" scoffed Vaughan. "They're only enforcing it in half. He's out in restaurants, he goes to the rollerskating rink. Now I'd like to see them put a policeman in his front yard and tell him he can't go out."

The parents had filed suit in the local Howard County court, but Vaughan, seeking to escape what he considered the hometown bias against White, was able to move the case, *Bogart v. White* (86-144) to the Clinton County Circuit Court in Frankfort, Ind. In April, Clinton Judge Jack O'Neill dissolved the restraining order, and White went back to school, but the parents have promised to appeal the case. Several, meanwhile, set up a private school so their two dozen or so children will not attend school with White.

District 27 v. New York City

An equally hot debate begat a more comprehensive decision in New York City, where two community school districts challenged the city's policy of letting children with AIDS attend school unless a special panel finds a reason for exclusion. In the first court ruling directly on the issue of schoolchildren with AIDS—the original White ruling discussed special education administration, but drew no conclusion on the AIDS issue—Queens County Supreme Court Judge Harold Hyman Feb. 11, 1986, upheld the policy based on federal antibias laws in *District 27 v. Board of Education of the City of New York* (14940/85).

An equally hot debate begat a more comprehensive decision in New York City, where two community school districts challenged the city's policy of letting children with AIDS attend school unless a special panel finds a reason for exclusion.

Robert Sullivan, attorney for the districts that challenged the policy, said he had no grounds on which to appeal. "Under the law, he [Hyman] probably did what he had to do."

Hyman's ruling "provides a lot of guidance for other lawsuits," said Doron Gopstein, New York City chief assistant

corporate counsel. "Anyone else will have to contend with this. In a technical sense it's not binding on another jurisdiction, but where you have a trial where the medical evidence is as high-level as it was here, and the legal analysis is that thorough," an exclusionary policy grows more difficult to defend, he said.

New York communicable disease law did not present the confusion such law precipitated in Indiana. City and state law clearly do not deem AIDS a communicable disease requiring students to be excluded from school, Hyman noted.

The five-week trial and the testimony of 11 medical experts also convinced Hyman the city health commissioner had come up with a reasonable policy he could not overturn. Because of the apparent nonexistent risk of transmission, Hyman wrote:

> [I]t would usurp the function of the Commissioner of Health if this court [ruled] ... that the non-exclusion policy was arbitrary and capricious or an abuse of discretion simply because in the court of public opinion, that particular policy was—perhaps, or possibly—not the best choice. Although this court certainly empathizes with the fears and concerns of parents for the health and welfare of their children within the school setting, at the same time it is dutibound to objectively evaluate the issue of automatic exclusion according to the evidence gathered and not be influenced by unsubstantiated fears of catastrophe. (The full text of the decision is reprinted in Appendix H.)

Hyman said students with a history of AIDS or even those misdiagnosed as having AIDS are protected by Section 504, which forbids handicap discrimination in federally aided programs or activities. Automatic exclusion would have violated the act, Hyman ruled. Excluding AIDS patients but not children with ARC or carriers of the virus would violate the Rehabilitation Act and the equal protection clause of the 14th Amendment, he added.

Board of Education v. Cooperman

In New Jersey, two school districts in March 1986 won a suit challenging Education Commissioner Saul Cooperman's right to adopt guidelines on schoolchildren with AIDS without their advice.

Ruling in the districts' favor in *Board of Education of the City of Plainfield v. Cooperman* (A-1378-85T5) and *Board of Educa-*

tion of Washington v. Cooperman (A-605-85T5), the appellate division of the state Superior Court in Trenton said adopting guidelines without consulting the school districts and public violated the state administrative code. Unlike Judge Hyman, who ruled in favor of New York while criticizing the city for making policy behind a "cloak of secrecy," the Trenton court ordered the state back to the drawing board to conduct hearings and adopt new guidelines.

The three-judge Trenton panel also said the procedures by which schools could have contested admission of a child robbed the districts of due process. The policy, although supported by medical evidence, gave "neither the Plainfield Board nor the Washington Board the opportunity to be heard" when they objected to state orders that they admit two infected children, said the panel.

> ***"The crying shame in New Jersey is that someone gave the commissioner bad advice, and it's cost two school districts a great deal of money to vindicate the right of other districts in the state."***
>
> ***—Victor E.D. King, attorney, Plainfield, N.J., school district***

The court said the state should consider students' rights to attend school, while also realizing that "classmates, faculty and staff have an equally important interest in being reasonably free from the risk of exposure to contagious disease which may be spread by students attending public schools."

Two judges on the three-member panel concluded that each exclusion requires a "careful examination" to determine its propriety, saying:

> Such an examination has never been made here. We believe there has been a sufficient showing of a potential risk of exposure to contagious disease to warrant hearings prior to the admission of [the Plainfield and Washington children] to classroom attendance. Furthermore, given the constitutional right of these children to an education and because they are still not being educated in an appropriate classroom setting, we direct that the Commissioner hold these hearings immediately, affording all parties the opportunity to be heard.

The state in April 1986 appealed the decision to the New Jersey Supreme Court. New Jersey Education Department

spokesman Roger Shatzkin said state officials felt pressed to act quickly in 1985 to establish guidelines for the approaching school year. "We thought ... we had instituted a process that was in the best interest of the children involved and all the children in the state," he said.

Plainfield's attorney, Victor E.D. King, saw the fault differently: "The crying shame in New Jersey is that someone gave the commissioner bad advice, and it's cost two school districts a great deal of money to vindicate the right of other districts in the state."

Other AIDS-In-The-Schools Cases

Educators elsewhere also have found their way into court—or very near the courthouse steps—in disputes over AIDS policies.

■ A student who has the AIDS antibodies but not AIDS itself was kept out of school for several months in Saddleback Valley, Calif. An Orange County Superior Court judge in February 1986 ruled that the boy, who has hemophilia, posed no risk and ordered the school to take him back in *Phipps v. Saddleback Valley Unified School District* (474981).

■ A group of girls in a high school dressmaking class filed a claim against the Los Angeles Unified School District in 1985, seeking the right later, if one develops AIDS, to sue the district for negligence in letting into class a male prostitute with AIDS, according to district general counsel Jerry Halverson.

School officials had "swept" a city neighborhood to coax him, and other teenagers living off the street, to return to school, Halverson said. The girls in dressmaking class were unaware of his background, and they shared his lipstick and drinking glasses and bandaged his hands when, in the normal course of a class with scissors and needles, he cut himself.

If they convert their claim into a negligence suit, the girls could charge school officials knew the youth was a prostitute, knew that male prostitutes have a high risk of getting AIDS, and failed to inform the class or the teacher of his background so that the class could take precautions.

But Halverson said the district had not been negligent, given medical knowledge at the time. "We brought these [street] kids in last summer," he said. "I don't think the district or even the

general public last summer recognized the hazard, if any, that an AIDS patient might be."

■ The Denver Civil Liberties Union in the 1985-86 school year offered to represent a high school student who is an asymptomatic AIDS carrier when it learned the student's parents and the Denver public schools were arranging homebound instruction, according to Michael H. Jackson, attorney for the schools. But the student, whose identity and circumstances are undisclosed, has not sought the group's help, Jackson said.

■ In Wisconsin, the Racine Education Association in early 1986 filed a complaint (ERD 8650279) with the Equal Rights Division of the state Department of Industry, Labor and Human Resources (DILHR), challenging a proposed Racine Unified School District policy that would exclude most students and teachers with AIDS, according to Frank Johnson, the district's director of employee relations.

The proposal, which is on hold pending advice from the state attorney general, says, "Students or district staff members who have ... [AIDS or ARC] are excluded from regular school attendance or attendance at work. Such afflicted students will be placed in alternative educational settings such as home tutoring ... [Employees with AIDS] will be placed on sick leave or leave of absence until a determination can be made about a further work assignment."

Under the draft administrative guidelines, Johnson said, the superintendent would give employees with AIDS temporary work assignments away from students or even other teachers, until the district determines what to do in the long term. The guidelines do not say how AIDS victims would be identified, he said.

A DILHR equal rights officer in a preliminary ruling April 1986 said there is "probable cause" to believe the policy violates the state Fair Employment Act, which bars job bias based on disability, and that it would disparately harm homosexual and bisexual men, who are protected by state law against discrimination based on sexual preference. Wisconsin also forbids use of current AIDS tests in employment decisions, but the policy does not state how AIDS carriers would be identified. Racine will have the chance to defend its policy in hearings before a DILHR officer.

Future Litigation: Section 504

AIDS litigation is slowly beginning to find a niche in the federal Rehabilitation Act and similar state laws, the 14th Amendment, P.L. 94-142, state and local communicable disease laws, tort law covering civil wrongs and negligence, contracts, confidentiality laws, the right to privacy, and codes of administrative procedure.

Attorneys generally agree that AIDS meets the definition of a handicap protected by Section 504 of the Rehabilitation Act. What is less settled is the extent to which schools and others must—or can—accommodate those with AIDS under Section 504, which states that no "otherwise qualified" handicapped person "shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Section 503 of the act similarly protects handicapped employees of institutions with federal contracts.

Hyman ruled that Section 504 applied to people with AIDS, ARC or a past infection of the AIDS virus. The statute defines a handicapped person as anyone with a physical or mental impairment that "substantially limits one or more ... major life activities," anyone with a "record of such impairment" and anyone "regarded as having such impairment."

> ***"You can drive a Mack truck" through the definition of handicapped in Section 504.***
>
> ***—Gwen Gregory, deputy general counsel, National School Boards Association***

The act's regulations note the law also covers anyone who has a handicap that is merely regarded as limiting major life activities or that limits those activities only as a result of others' attitudes. It also covers anyone who has no impairment but is treated by the federal aid recipient as having one.

Even if those sections did not apply to AIDS, the disease would be covered by the regulatory definition of physical impairment, which includes physiological disorders. People with AIDS probably can claim coverage for both reasons, Hyman said.

Hyman also referred to a 1985 ruling, *Arline v. Nassau County School Board* (772 F.2d 759), in which a federal appeals court for the first time defined a chronic contagious disease as a handicap under Section 504. The 11th U.S. Circuit Court of Appeals said the Nassau County, Fla., school board must try to find a job in which it could continue to employ the third-grade teacher it had fired because she was susceptible to tuberculosis. The Section 504 regulations require such "reasonable accommodation" in handicap bias cases.

In its opinion, which reversed a lower court ruling, the 11th Circuit stated:

> When a fact pattern falls so neatly within the statutory and regulatory framework, and when coverage would so clearly serve to promote Congress' intent to reduce instances of unthinking and unnecessary discrimination against those who are the focus of the statute's concern, we would be hard pressed to find an exemption.

There still may be a question over the degree of accommodation required, however, because the U.S. Supreme Court in April 1986 agreed to review the *Arline* ruling. The court may have been responding to Nassau's contention that, when safety concerns arise not because of the effect of a handicap such as blindness on the worker's ability to perform a job, but because of the individual's "mere presence on the job site," the danger "cannot be eliminated or minimized through 'reasonable accommodation.'" In an unusual move, the Court framed its own question to address in the case: "Whether one who is afflicted with the contagious, infectious disease of tuberculosis is precluded from being 'otherwise qualified' for the job of elementary school teacher, within the meaning of Section 504?"

Most attorneys are in step with Hyman and the 11th Circuit in viewing AIDS under Section 504, especially if tuberculosis is covered. "I cannot for the life of me imagine how you could say that a contagious disease does not 'affect one or more life activities,'" said Gwen Gregory, deputy general counsel of the National School Boards Association (NSBA). "Especially since the act talks about perceptions—it doesn't even matter if you're disabled. You can drive a Mack truck through that definition." But Gregory said it is not necessarily the case that all those with contagious handicaps can be accommodated. She noted, though, that because tuberculosis can be quite contagious, a rul-

ing limiting the duty to accommodate tuberculosis patients would not necessarily have any bearing on AIDS carriers.

Michael Simpson, staff counsel with the National Education Association (NEA), said another "big problem" with Section 504 is trying to prove liability in "a school district that has federal funding only under Chapter 1 [remedial education under the Education Consolidation and Improvement Act], or some other special service law."

Under the Supreme Court's 1984 *Grove City College v. Bell* (104 S.Ct. 1211) ruling, federal aid does not necessarily make entire institutions subject to Section 504, but only the "program or activity" receiving federal money.

And, of course, Section 504 does not protect students or employees at the many private elementary and secondary schools and few private colleges that get no or little federal aid. Private schools "have a lot of leeway in who they let in, who they hire," said Gregory. "I think there's very little that can be done [by excluded students or teachers], except maybe [suing for] breach of contract. You have a contract to let your kid go to school, or to teach, [which would be violated if] they don't let you in."

State Job Discrimination Claims

Where Section 504 does not apply, state laws against handicap discrimination may, especially in the workplace. "Most states prohibit discrimination against handicapped individuals by public and private employers," according to a report by attorneys at Seyfarth, Shaw, Fairweather and Geraldson, a leading management labor law firm. Of those states that do not bar job discrimination in both public and private sectors, five—Alabama, Arkansas, Idaho, Mississippi and South Dakota—forbid job bias by public employers, according to the Seyfarth report.

Only Arizona, Delaware, Puerto Rico and the Virgin Islands lack laws prohibiting discrimination against handicapped people, according to the Seyfarth report and a guide published by the American Management Association.

While several states define handicap as the federal law does or include broad nets such as "having a record of such impairment" or "regarded as having such an impairment," some cover a narrower group, the Seyfarth report notes.

Moreover, Georgia, Kentucky and North Carolina "let employers reject applicants with communicable diseases," and North Carolina also allows action against current employees with communicable diseases. The question then becomes whether AIDS is "communicable" in any sense meaningful at work.

Most suits so far have come under state laws, including the first AIDS-related job discrimination suit decided, *Shuttleworth v. Broward County Office of Budget and Management Policy* (FCHR 85-0624), which rested on the Florida Human Rights Act. In that case, the Florida Commission on Human Relations decided in December 1985 that a budget office employee with AIDS was handicapped because he "does not enjoy in some manner, the full and normal use of his sensory, mental or physical faculties." The commission said the county lacked "evidence to show with any reasonable probability that AIDS can be transmitted by casual contact that commonly occurs in the workplace."

Pending in Ventura County, Calif., before the state Department of Fair Employment and Housing, is a similar case filed in 1984, *Chadbourne v. Raytheon Corp.*, in which the defense contractor fired a man with AIDS, refusing to rehire him unless he proved the virus could not be transmitted casually or that there is a cure for AIDS. Although the man has since died, the San Francisco-based National Gay Rights Advocates is pursuing the case based on state job discrimination law, according to Benjamin Schatz, director of the group's AIDS Civil Rights Project.

The 14th Amendment

In rejecting exclusion of AIDS students from school in his ruling on New York City's policy, Hyman used the 14th Amendment, which says no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Gregory and others said the 14th Amendment, like Section 504, could apply broadly, outlawing distinctions between those with and those without the virus, not just among those with different AIDS-related conditions.

But Hyman applied the 14th Amendment as he applied Sec-

tion 504, contrasting treatment of AIDS patients to treatment of people with other AIDS-related conditions:

> Absent any rational basis for ... exclusion of only known AIDS cases or carriers to the virus, without imposing such exclusion in the case of ARC patients or asymptomatic carriers who are as likely to present a risk of contagion because they too are infected ... such a proposal must be deemed a denial of the equal protection of the laws.

In that respect, said Hyman, the case parallels *New York State Association for Retarded Children v. Carey* (466 F.Supp. 479; aff'd 612 F.2d 644), in which a federal district court, affirmed by the 2nd Circuit in 1979, said separating handicapped carriers of hepatitis B from their classmates would violate the 14th Amendment because there was no effort to discover and exclude non-handicapped carriers, including teachers and staff.

In their separate briefs for Indiana's Western School Corp. and the Plainfield, N.J., board of education, however, Day and King each attacked *Carey*, using two later cases that ended in more restrictive decisions because they arose when the medical community learned how easily hepatitis B is transmitted.

"Medical evidence [in *Carey*] regarding the transmission of the virus was hauntingly familiar to the testimony ... of the CDC and [Indiana] guidelines," said Day. "In language reminiscent of racial segregation cases (the court even cited *Brown v. Board of Education*), the court completely discounted the public health issues and the concerns of school administrators, teachers and staff."

But within two years, in another case, a student caught hepatitis B "in a school setting, and transmission through saliva had been confirmed," Day noted. In that case, *Ely v. Howard County Board of Education* (Civil Action M 81-3072), the U.S. district court in Maryland ruled "the risk of injury to the ... school corporation and its employees outweighed the undeniable harm exclusion caused the student," according to Day. At about the same time, a California state administrative officer reached the same decision regarding the appropriate placement of a special education student in *In re Santa Clara County Superintendent of Schools* (Case No. SE-427, decided Feb. 1, 1982, by the state Office of Administrative Hearings, San Jose).

Western also pointed to "the chilling similarities between the

medical evidence in *Carey* and that presented" in Ryan White's case. At the time of *Carey*, medical experts thought hepatitis B could not be transmitted at school or by casual contact, and the precautions they recommended amounted to good hygiene.

Communicable Disease Laws

Aside from handicap bias laws, four California cities—Los Angeles, San Francisco, West Hollywood and Berkeley—prohibit discrimination against persons with AIDS-related conditions, according to Seyfarth.

Moreover, California, Florida and Wisconsin bar employment decisions based on AIDS testing, and Berkeley bars AIDS testing by employers, Seyfarth reports. In addition, Wisconsin, the District of Columbia, New York City and Austin, Texas, laws prohibit discrimination based on sexual preference, and might be the basis, as in *Racine*, for disparate impact claims against policies that exclude AIDS victims, even where an employer's motive is not specifically anti-gay.

At least 15 states require schools to exclude students with communicable diseases. Some broaden coverage to exclude students 'suspected' of having a disease or 'exposed' to a disease.

While many legal observers said discrimination law favors those with AIDS, public health laws could limit the freedom of AIDS patients. "Mayors, governors, presidents don't have the power public health officials do. Where you get into public health issues—in imposing quarantine or closing public facilities, for example—"the power you can exercise is frightening," said New York City's Gopstein. Gopstein in 1985 won a suit to close gay baths to curb the spread of AIDS.

At least 15 states require schools to exclude students with 'communicable' diseases, according to NSBA. Some statutes broaden coverage to include students 'suspected' of having a disease (Connecticut), pupils who have been 'exposed' to a disease (New Jersey), and students and teachers 'of a household exposed to contagion' (Massachusetts, New Jersey). Several statutes apply to both students and teachers.

NSBA recommends that school districts consult with public health officials on the communicability of a disease before deciding to exclude or admit those with such diseases.

Privacy Law

Because the side effects of AIDS can range from the unease displayed by a neighborhood grocery clerk to outright discrimination against homosexuals, suspicions of drug use, and job loss, privacy is a paramount concern. Schools and colleges must consider the issue when they frame policies, as anyone breaching the confidentiality of an AIDS carrier risks being sued for defamation, emotional distress, or violation of the 14th amendment.

It would be difficult for a school to justify knowing the results of AIDS testing on employees and students, let alone performing the tests.

Privacy law does allow "justifiable" infringements. Observers on all sides of the issue agree it would be difficult for a school to justify knowing the results of AIDS testing on employees or students, let alone performing the tests. "You would have to show a rational basis, and I don't see any," said NSBA's Gregory. "So someone tests positive. They don't necessarily have the disease, and if they do, so what?" because medical evidence says AIDS will not spread in casual settings such as schools.

Even harder to justify legally, say attorneys, is forced or secret testing, where, for example, blood drawn in annual physical examinations would be tested for the AIDS antibody either with or without notifying the employee. A blood test is a search, and a required or secret blood test for AIDS is probably an unreasonable search, which public schools may not conduct without violating the 4th Amendment, lawyers almost uniformly say.

Several lower courts have struck down random or uniform testing, such as for drugs, where there is no "individualized suspicion" of a condition that is anyone's business. "I think the random blood testing of public employees is impermissible," NEA's Simpson said. Private schools, however, are not bound by the 4th Amendment, several school lawyers cautioned.

Students also have the protection of the 1974 Buckley amendments, formally the Family Educational Rights and Privacy Act (See Appendix I). The act requires schools to get written parental consent before releasing a student's educational records, including school medical records, according to Patricia Ballinger,

a privacy act administrator at the U.S. Education Department. Parents also may ask the school to correct misleading records. The penalty for violating the act is loss of federal funds.

Parents' rights under the act shift to students when they reach age 18 or attend a school beyond high school. The act does not give college students the right to review the school's medical records on them.

Moreover, each school makes its own rules on disclosure to school employees with "legitimate educational interests," other schools to which a student transfers, the student's financial aid sponsors, and individuals who need to know in cases of health and safety emergencies.

Students also have the protection of the 1974 Buckley Amendments, formally the Family Educational Rights and Privacy Act. Schools must get written parental consent before releasing a student's school medical records.

"I think the courts will say that if there is a duty to tell the teachers [of a child with AIDS], it's not for the protection of the teachers but for the protection of the child because there seems to be no reason for teachers to know for their own health," said NSBA's Gregory. "There probably is a common law duty to protect employees from known hazards," and schools that fail to do so may risk negligence liability. But "the question always comes back to, 'Is it a hazard?' and I think the courts will say it's not," she said.

Hartog-Rapp disagrees. "Illinois has a right-to-know law requiring employees to know about dangers in the workplace, and that could be applied," she said. "Therefore I have some difficulty about not informing the teacher. For example, in an industrial arts class, a student may cut himself." Even if teachers know proper clean-up procedures, a teacher who knows a student has AIDS may be "particularly attentive."

But Hartog-Rapp said she would "inform employees in strict confidence," telling them to keep the information "within the universe of the kid's teachers."

Many teachers do want to know, but NEA's Simpson said the issue is not necessarily a legal one. "I don't know that teachers have any statutory or constitutional right to know, but it's our

policy they should," he said. Simpson said right-to-know laws would not apply, because AIDS is not a "hazard."

Like students, teachers can be asked for medical information. Schools can ask about AIDS to the extent they ask about other health conditions that might affect work performance, but they cannot use that information to discriminate, said Carol Whitten, attorney for the Chicago school district.

Discriminatory use of test results is one of the concerns of the Racine Education Association, which represents the teachers challenging the exclusionary policy proposed by the Racine, Wis., school district. Wisconsin bars use of the test in job decisions, but the teachers' contract subjects them to triennial physical examinations, whose results go into personnel files that teachers can't see, according to Jim Ennis, executive director of the association.

P.L. 94-142

Opinion is split on whether P.L. 94-142 applies to children with AIDS. P.L. 94-142 defines handicap more narrowly than does the Rehabilitation Act, and most education lawyers say it does not necessarily apply to AIDS. In the New York case, Hyman decided the law was not necessarily relevant:

> The pivotal question is whether a child diagnosed as having AIDS would fall within the definition of a 'handicapped child.' ... Under [P.L. 94-142], the term includes those children evaluated as being health impaired who, because of those impairments, need special education and related services. Health impaired is defined as 'having limited strength, vitality or alertness due to chronic or acute health problems ... which adversely affect a child's educational performance.' Thus, while a child with AIDS could become handicapped as a result of deterioration in his or her condition, the evidence clearly supports the determination that such children are not handicapped for purposes of referral to a [P.L. 94-142 evaluation team] merely because they have AIDS/ARC or are infected with the virus.

Handicap rights attorney Martin Gerry put it this way: "The first question is, does the child have a physical condition? The answer is yes. The second question is, does the condition have an adverse affect on the child's education? That may or may not be

the case. The third question is, does the child need special education?" AIDS is most likely to demand special education when the infection spreads to the central nervous system, he said. "It's possible the attention span is short. The child can't read for more than 10 minutes at a time. At that point, the answer to special education may be, yes."

P.L. 94-142 is "not a civil rights statute," noted NSBA's Gregory. "It's a funding statute. If the kid doesn't need special ed, it shouldn't be funded."

Some state laws implementing P.L. 94-142, such as Indiana's, are more inclusive. As the appeals board noted in Ryan White's case, children are eligible for special education under Indiana regulations if they suffer from a health impairment that limits "strength, vitality, or alertness and is caused by a chronic or acute health problem, ... demands a need for greater protection than the regular school program provides" or results in inability to function in the regular school program. The hearing examiner said White qualified because both hemophilia and AIDS are chronic health problems.

Opinion is split on whether P.L. 94-142 applies to children with AIDS.

AIDS decisions so far conflict on P.L. 94-142, said Seyfarth attorney Fay Hartog-Rapp, who represents several Illinois school districts. She noted that the first Ryan White decision treated it as a special education case requiring administrative resolution. "Then you have [the New York ruling], which says it's not necessarily a handicapping condition. In my opinion, being a carrier or having the disease is not going to be considered a handicapping condition under P.L. 94-142 if it goes up to a higher court."

Hartog-Rapp said she would not be surprised if schools apply for federal P.L. 94-142 reimbursement for children with AIDS. "There are obviously considerations of equity which might persuade a judge or a court not to take the legally most pure course," she said. "If the parents and school concurred on a P.L. 94-142 placement, a court may well go along with that." The U.S. Education Department has not taken a stand on whether children with AIDS are covered under P.L. 94-142. But Madeleine Will, U.S. assistant secretary for special education and rehabilitative services, has said schools should determine,

case-by-case, whether a child with AIDS needs special education.

Both Hartog-Rapp and Plainfield, N.J., lawyer King suggest schools at least use P.L. 94-142 procedures. "Why not?," asked King. "You've got all these health regulations in your state; you've got all these special education procedures. Why create something else?" just for children with AIDS-related conditions.

If the child had tuberculosis, "it would be special education," King said. "Why does there have to be a difference [in the case of AIDS]? Pragmatically, it doesn't make sense." The majority of children with full-blown AIDS qualify for special education anyway, he argues. "They don't attend school. They're in and out all the time, depending on what they catch." White, for example, took homebound class only 11 of the first 47 days of school in fall 1985.

Higher Education Issues

AIDS also raises legal issues of particular interest to colleges and universities. "The compulsory attendance laws vest in the student a greater property interest in elementary and secondary school than in the postsecondary level," noted Hartog-Rapp. "If you're required to attend school and pay tax dollars for it," there is a stronger presumption of a child's right to attend. "At the postsecondary level, there is less of an expectation."

> *"It's a whole different thing to say you have to share a shower with" a known AIDS carrier.*
>
> *—Fay Hartog-Rapp, attorney, Chicago*

Dormitory living complicates the legal questions colleges face, attorneys note. "It's a whole different thing to say you have to share a shower with" a known AIDS carrier, said Hartog-Rapp. "I'm not saying it's medically different, but it's perceived differently." (For a more extensive discussion of higher education issues, see Chapter Seven.)

In litigation over the rights of college students with or without the AIDS virus, "I would see the court balancing the liberty interest against the right of the other student to be free of health hazards, and going with the latter," she said.

But the legality of favoring other students' rights would de-

pend on the kind of restrictions a school imposed on AIDS carriers, Hartog-Rapp said. Schools must join restrictions with meaningful accommodation. For example, she suggested, a college may be allowed to admit students with AIDS subject to the availability of private rooms, but only if the college actually has some private rooms.

Colleges and universities, like inns and restaurants, bear a recognized responsibility under tort law to protect their invited patrons—students—from unreasonable risk, said Sheldon Steinbach, general counsel of the American Council on Education (ACE), in a 1985 legal paper on AIDS. But they need not undertake "unrealistic duties to supervise their students," Steinbach noted, citing legal precedent.

Institutions that adopt policies may want to insulate known AIDS carriers from close contact with others, Steinbach said. While institutions could be in legal quicksand if they disclosed the names of known AIDS carriers, they might consider requiring students with the virus to inform their roommates, he wrote.

> ***"A school may face the need to consider suspending, expelling or otherwise disciplining an AIDS victim who fails to heed counseling and engages in conduct known likely to infect others."***
>
> ***—Sheldon Steinbach, general counsel, American Council on Education***

Schools also may want to protect themselves by requiring students or employees with AIDS to submit to monitoring and counseling against activities that can transmit the virus, Steinbach said in the paper. Schools that institute a monitoring program should intervene quickly if they learn a student is engaging in activities that could spread the disease, he added.

"A school may face the need to consider suspending, expelling or otherwise disciplining an AIDS victim who fails to heed counseling and engages in conduct known likely to infect others, or it may have to decide whether to disclose to others that they have been exposed to [the] AIDS virus through contacts with a person known to be infected," he said.

But colleges need not undertake "unrealistic duties to supervise their students," Steinbach noted, citing legal precedent.

As others urge in the elementary and secondary arena,

Steinbach suggests colleges publish their AIDS policies throughout their communities to "foreclose any charges that potential risks had been unreasonably 'concealed.'" On the same principle, information campaigns on AIDS "should contribute both to reducing the spread of AIDS and to demonstrating schools' efforts to exercise reasonable care in protecting the academic community from the disease," he said.

But, in advice that touches precollege health courses too, Steinbach notes, "Questions could be raised in some jurisdictions whether such counseling and informational programs promote or advocate 'immoral' conduct contrary to statutes prohibiting sodomy or other sexual practices." (See Chapter Six for a discussion of the issues surrounding AIDS education in the schools.)

"The question may be of particular concern if the Supreme Court upholds such statutes against a constitutional challenge" to Georgia's sodomy statute in *Bowers v. Hardwick* (54 USLW 3657), on which the Court held arguments in March 1986, Steinbach added.

Other Legal Issues

Other legal concerns on which little case law exists include terminating a teacher with AIDS out of fear for the teacher's safety, pension rights and a school's concern about the employee's ability to continue performing.

Courts have let businesses fire employees to protect the employee's own health, provided they scientifically document the increased risk and try first to accommodate the worker in another job, as Section 504 directs. Schools have the added burden of proving good cause for terminating tenure.

NEA's Simpson, however, said, "I don't think you're going to see much litigation [on the issue] unless it's over medical benefits. First, the classroom is a breeding ground of infection, as we all know, and a person with AIDS is susceptible to those infections," and many will not want to remain, he said.

"Second, if a person is diagnosed as having AIDS, they don't want to spend their last year or two in the classroom, and they may be so weak they may be unable to teach," he said.

"I would anticipate that a school district that has sound legal advice would take some other action, such as transferring the

teacher to another job where he doesn't come into contact with children or even other employees," Simpson said. "The legality of such a transfer would depend on state law or the teachers' collective bargaining contract." For example, some contracts give teachers the right to veto transfers.

The Seyfarth report notes several cases offering guidance, although they are not binding beyond their narrow jurisdictions:

- *In re United Airlines*, a 1985 arbitrator's decision ordering the airline to reinstate a flight attendant who was fired when he revealed he had AIDS;
- *Mantolete v. Bolger* (767 F.2d 1416, 1422), in which the 9th Circuit in 1985 said the mere increased risk of harm to others did not justify refusal to hire a person with epilepsy;
- *Chrysler Outboard Corp. v. DILHR*, in which a Wisconsin circuit court in 1976 ruled it unlawful to reject a terminally ill job applicant simply because of future inability to perform the job; and
- *Folz v. Marriott* (594 F. Supp. 1007), in which the U.S. district court in Western Missouri in 1984 ruled it a violation of the Employee Retirement Income Security Act to terminate an ill employee to avoid weakening the benefit plan.

Also, according to the Seyfarth report, many state courts allow suits for wrongful discharge, where the firing "violates public policy." State handicap laws may be sufficient indications of public policy to support those claims, according to the report.

How Much Litigation?

AIDS is not a high volume legal problem, but when it happens it is a high intensity problem. The question is, to what extent will litigation be a concern?

"I don't know—ask a sociologist," said Gregory. "Let's face it, you can't keep people out of court. Parents get scared and they want to fight. You can't avoid a lawsuit. All you do is avoid losing."

"I am certain there will be another Ryan White case at the high school level," said Hartog-Rapp. "No matter what we try to do to educate people about the need for a cooler head, there is going to be, somewhere, a high school student who has con-

tracted AIDS on his own, by sexual conduct [and the school will find out]. The issue will then become, to what extent is a public school required to accept" a community member who has caught AIDS by his or her voluntary behavior.

"The employment area is one of the ones where I'm most optimistic" that courts will require inclusion of people with AIDS, said Schatz of the gay advocates group. "The school cases are more politically sensitive, but, legally, the analysis should be the same," he added. "Legally, there's no more place for irrationality and hysteria in the context of children than in any other context."

> ***"Legally, there's no more place for irrationality and hysteria in the context of children than in any other context."*** ***—Benjamin Schatz, director, AIDS Civil Rights Project, National Gay Rights Advocates***

Schatz foresaw new issues arising from legislation, such as two versions of a bill pending as of May 1986 in Colorado, to mandate testing of, or to allow health officials to examine those "reasonably suspected of harboring the virus," and to quarantine infected individuals.

But Plainfield, N.J., attorney King expects "a lot more litigation" similar to the back-and-forth suing in Kokomo, Ind. "It's kind of bizarre that after the school district said he [White] could come in, they get sued. Talk about fertile ground for further litigation, this is it."

What Schools Can Do

If schools want to avoid potentially costly litigation, there are several steps they can take:

- Figure out, under state and local law, who makes the key policy decision regarding disease in your state, Gopstein advises. It may be education officials or health officials.

- Remember that in law, as in medicine, prevention is the healthiest practice. Base decisions on sound and current medical information from reliable sources. The CDC guidelines and other medical evidence "provide a basis for arguing that transmission through routine personal interaction is not reasonably foreseeable and that any transmission is probably

the result of private individual conduct for which the [school] should not be held responsible," as Steinbach contends in his ACE paper on colleges.

"Although you never can tell what a judge is going to do for reasons that have nothing to do with the law, only to do with emotion," Gregory predicted, judges will be hard pressed to overturn a decision to include children with AIDS if the school has acted reasonably, with medical support.

■ Think through your defenses against litigation to aid cool-headed decisionmaking. "We are not insurers," said NSBA general counsel August Steinhilber. "We don't guarantee the absolute safety of the bus, the boiler, and so on." Nor can schools guarantee absolute freedom from infection.

Conclusion

Litigation over AIDS is in its infancy, but one obvious conclusion schools can draw is that a policy, drafted with public comment before AIDS strikes, is the best defense against possible legal action.

"Any response should be a carefully considered one, taking account of informed medical and legal advice, rather than a 'reflexive reaction' of prejudice against—or sympathy for—AIDS victims," Steinbach advises.

By putting policies in place, "you allay fears," said New York's Gopstein. "In particular cases it may avoid a lawsuit. You'll never know how many other incidents and lawsuits it might prevent, but there is no doubt it prevents some."

How should schools go about setting up a policy? Chapter Five takes you through the process, step by step.

Chapter Five

How to Develop an AIDS Policy

If anybody should know, it's James O. Smith, who had the unenviable task of making a decision about a student with AIDS in the glare of national and even international publicity.

Learn from his experience, says Smith. "Develop a policy before you have a problem," and are forced to develop a policy—as he was in Kokomo, Ind.—after the public learns a student has AIDS.

"Once you're into a situation, it's not a very good time to draw up a policy," said Smith, superintendent of the Western School Corp., which has been embroiled in court cases over teenage AIDS patient Ryan White. "I mean a well-developed, coolly thought-out decision on how you would act."

Why You Should Have An AIDS Policy

Not everyone sees the need to develop an AIDS policy. "We have a certain midwestern smugness about it," said a school administrator in Nebraska, where no pediatric AIDS cases have been reported. "I think what you find is unless a state or school district has a case on their hands, they won't know too much about it."

That attitude is all too common, but it's a mistake to think AIDS only happens to people in heavily populated urban centers, said Dr. Martha Rogers, who heads the pediatric AIDS unit at the U.S. Centers for Disease Control in Atlanta.

As the examples of rural Kokomo, Ind., and Ocilla, Ga., (see Chapter Two) point out only too well, it's in all schools' best interest to develop a policy, said Rogers. "They need to decide what they should do if faced with the problem. They need to start educating, start getting other parties involved, the parent-teacher groups and so forth. Make them aware of the facts."

Richard Miller, executive director of the American Association of School Administrators (AASA), also urges schools to set up a policy before they have a problem. "If you wait until a problem occurs, you'll be in a reactive mode and not be as constructive in your thinking as you should be."

While some states, like Nebraska, have had no cases of AIDS in children, all states have had AIDS cases in adolescents or adults (See Figure 4). Some of those adolescents could be your high school students. Some of those adults could be your teachers.

Obviously, the problem is significantly worse in certain states, mainly New York and California, and within those states, in certain cities, mainly New York City, San Francisco and Los Angeles. But it only takes one student or staff member with AIDS to cause a crisis in your school district.

How To Come Up With A Policy

Start with the CDC guidelines, but don't simply adopt them. Adapt them to fit your school's needs.

"Develop a policy before you have a problem." —James O. Smith, superintendent, Western School Corp., Kokomo, Ind.

"Our guidelines were never meant just to be transferred, they were meant to be a guide," said Rogers. "A lot of things differ in certain situations." Schools for mentally retarded children, for example, have different needs than regular schools, she noted, because retarded children can have certain behavior problems and can be more susceptible to infection.

"Every school's rules could be different, but with the same spirit," said Rogers. Every school should base its rules on the underlying medical information upon which the CDC rules are built: that AIDS is not spread by casual contact. And every school, recommends Rogers, should adopt the principle of individual assessment of each child, but can make its own decision on exactly who should participate in the assessment. "Those kinds of details could vary from school to school," she said.

To adopt the CDC guidelines to a particular school district or state, educators should consult local or state health departments and an attorney familiar with both education and health law in

your state, because state law varies. For instance, in some states AIDS is considered a communicable disease; in others, it is simply a "reportable" disease.

AASA strongly recommends that school administrators work with their local medical authorities to set up guidelines. "Schools should start with the CDC guidelines, then go to medical authorities," Miller said.

> ***"There is no reason to keep all children with AIDS out of school. The decision has to be made child by child."*** ***—Dr. Louis Cooper, director, pediatric service, St. Luke's-Roosevelt Hospital Center, New York City***

If school officials think health officials aren't cooperating, the school district should go to court and "ask the court to require the public health department to put up or shut up. Either certify he should, or certify he should not be admitted to school," said Gwen Gregory, deputy general counsel for the National School Boards Association (NSBA).

The worst thing a school can do is act without guidance from CDC or local health authorities, said Washington, D.C., attorney Martin Gerry, who advises school districts on issues relating to handicapped children and AIDS.

"I've been saying to school districts who call me,'You have to go to CDC first, then to state health authorities who we assume will follow CDC. If the state public health agency has a policy, follow it, if not, follow CDC,'" Gerry said. "What's happened is a whole bunch of school districts have decided to leap into the breach. I think that's unwise. It's okay for a school board to set a policy to decide to follow the public health policy."

If schools involve public health agencies, they will have experts to back them up if the public doesn't like their decision, Gerry said. "In schools, what happens, I think, is a political problem. Two or three or more parents go bananas on them, we get doomsday, the world's going to end, the sky's going to fall. . . . Schools need to bring somebody else onto the stage who at least is responsible. I'm not pumping up state public health agencies, but they do know more than school districts" do about AIDS.

It's also crucial that school officials consult with teachers,

parents and the community. As described in Chapter Four, a state court in March 1986 set aside New Jersey's policy requiring schools to admit children with AIDS, in part because officials did not involve the public enough in making the policy. And New York City officials faced a massive court battle because they did their decisionmaking in secret.

The American Federation of Teachers' (AFT) draft policy on AIDS calls for all school district AIDS policies to reflect "consultation with designated employee representatives, public health officials, parents and appropriate community agencies and organizations."

And the National Education Association (NEA) guidelines state that "the recognized employee organization should be involved in the development of . . . guidelines and any dispute as to their meaning or application should be subject to the appropriate grievance/arbitration procedure." (The NEA and AFT guidelines are reprinted in full in Appendices C and D.)

"Everyone wishes the problem of AIDS would go away. School officials are no different. But school officials can't solve the problem simply by excluding" students and employees with AIDS.

—Gwen Gregory, deputy general counsel, National School Boards Association

Not everyone agrees schools should go public in writing an AIDS policy. Others favor a low-key approach. "To further inject ourselves into the overall confrontation is unwise management and foolish," said Kelly Frels, a Houston attorney who specializes in education. Frels said he would recommend schools insert a passage about AIDS into their regular policy on communicable diseases, rather than setting up a policy solely on AIDS.

Gregory agreed it is "probably unnecessary" to develop a separate policy on AIDS if schools have one on infectious diseases.

But because of the differences between the way AIDS and most infectious diseases are spread, and because of the public outcry this issue can raise, most experts agree schools would be wise to write a separate policy—before they are forced to—and do it at least partially in public.

What Your Policy Should Say

■ Lean toward inclusion of students and staff, not exclusion. Both medical and legal experts on AIDS recommend that school policies aim to include students and staff. They also agree decisions should be made on a case-by-case basis. "There is no reason to keep all children with AIDS out of school. The decision has to be made child by child," said Dr. Louis Cooper, director of pediatric service at St. Luke's-Roosevelt Hospital Center in New York City.

> ***"In schools, what happens, I think, is a political problem. Two or three or more parents go bananas on them, we get doomsday, the world's going to end, the sky's going to fall."***
>
> ***—Martin Gerry, Washington, D.C., attorney***

Schools will be hard-pressed to justify legally a decision to remove a student or employee from the classroom unless there is hard medical evidence to back it up, said NSBA's Gregory. "Everyone wishes the problem of AIDS would go away. School officials are no different. But school officials can't solve the problem simply by excluding" students and employees with AIDS.

School officials are rightfully concerned as well with whether children with AIDS will catch other infections from their classmates. The risk certainly exists, said Cooper, but the child's physician should decide whether the benefits to the child of attending class outweigh the risk.

■ Require a panel to handle the case-by-case decisions on AIDS patients. Make the panel as broad-based as possible. At the very least, include the child's physician, his parent or guardian, and public and school health personnel. Add other school personnel if appropriate.

■ Delineate responsibility between regular and special education for students with AIDS. It is currently unclear whether children with AIDS qualify for special education under the Education for All Handicapped Children Act, P.L. 94-142. It is clear, as discussed in Chapter Four, that both students and employees with AIDS are protected under Section 504 of the 1973 Rehabilitation Act. (Relevant sections of the two laws are reprinted in Appendix I.)

The Council for Exceptional Children "believes that having a communicable/contagious disease does not in itself result in a

need for special education," according to a policy statement approved at the group's April 1986 convention. CEC's approach calls for individual assessment of each child, not automatic placement in special education.

Even though the law is unclear on whether AIDS students are covered by P.L. 94-142, schools should include in their policy who will be responsible for educating these students, to avoid internecine battles down the road. In addition, some attorneys suggest schools use existing P.L. 94-142 procedures for case-by-case evaluation of children with the AIDS virus. If you use the procedures, specify if you are using them for ease or because you consider the child eligible or potentially eligible for special education.

While the public "has a fear of science and medicine," schools "shouldn't let fear dominate their actions." ***—Dr. Harold Jaffe, chief, epidemiology branch, AIDS program, U.S. Centers for Disease Control***

■ Set up basic hygiene standards for handling blood and other body fluids of all children and employees, not just those with AIDS. Ensure each school has a supply of basic cleaning materials, such as household bleach, which CDC and other medical experts recommend for cleaning soiled surfaces. And ensure that teachers and other staff know what the procedures are. "It's prudent to use gloves and disinfectant when you treat anything that comes out of a child's body," whether or not they have AIDS, said Dr. Mervyn Silverman, national spokesman for the American Foundation for AIDS Research.

■ Set up standards of confidentiality. Decide who really has a "need to know" that the child or employee has AIDS. Experts are divided on this; schools should make the decision based on their individual situation, in consultation with their attorney. Silverman argues that because there is no risk to employees or other children from a child with AIDS, "the civil rights of the child outweigh the right to know."

Revealing a child's name to a select group of teachers would be "fine in a perfect world," Silverman said. In the real world, however, word travels fast, and before you know it, all the teachers know, word filters out to the parents and they're telling their kids to stay away from the child with AIDS, he said.

Gregory made a similar comment: "It may be an unrealistic guideline to tell only a few people. I've had people break out laughing when I say that, because in many schools, when one person knows, everybody knows."

■ Mandatory screening of children or employees should not be part of a school or state policy. CDC recommends screening only those in high-risk groups for the AIDS antibody. Schools cannot justify the expense of mandatory screening and they will certainly face court battles from employee unions or other advocates should they try to implement such a policy. Although "there isn't much litigation at this point" on testing, "we would be ready to fight," said Benjamin Schatz, director of the AIDS Civil Rights Project of the National Gay Rights Advocates.

■ If a student or employee with AIDS is in school, treat him or her like anyone else. "How tragic to have a student with AIDS traumatized by a teacher who puts him in the back of the class or by students who taunt him," said Silverman.

Conclusion

Experts make it clear that every school needs to come up with a policy on AIDS, and that the policy must defer to medical expertise on the subject.

That's easy to say, but not so easy to put into place.

As demonstrated in Chapter Three, it takes strong leadership and guts. In New York City, parents and their children carried coffins in the street to protest the AIDS decision. In Swansea, Mass., they collected money to help a teenager with AIDS and his family. The scenario you get depends greatly on how school officials make and carry out their decisions.

"In Swansea, Mass., they were able to pull it off, but it required a lot of meeting, a lot of education, a lot of prior planning for this child. I think that's really what you need," said CDC's Rogers.

Dr. Harold Jaffe, chief of the epidemiology branch in CDC's AIDS program, cautioned that while the public "has a fear of science and medicine," schools "shouldn't let fear dominate their actions. We have to be reasonable. If we're not, fear of AIDS will rival AIDS itself."

Schools, Jaffe said, also must be aware that their actions set an example for the community at large. "We can look at this

issue and say, 'There is a small risk. Maybe they don't need to go to school. Let's play it safe and keep them out of school.' That sets a bad precedent. An employer sees that and says,'If the school board is keeping them out of school, maybe I shouldn't let an employee with AIDS go back to work.' The hospital says, 'Maybe we shouldn't treat patients with AIDS.'"

Hand in hand with setting a good example for the community is setting a good example for students and turning what could be a crisis into a learning experience. Experts agree that schools, whether or not they have a child with AIDS, must add AIDS education to the curriculum. Chapter Six tells you how.

The Need For Education

Because most of the schoolchildren who have developed AIDS so far have been exposed to the virus through contaminated blood, schools have been able to avoid the issue of how AIDS is most commonly contracted: through sex and intravenous drug use.

That issue can be avoided no longer. The numbers of those who are exposed to the AIDS virus through contaminated blood or blood products are expected to dwindle to practically zero, because the blood supply has been cleaned up. And while children will continue to get the disease from their mothers at birth, most of them unfortunately die before they reach school age.

Schools must begin to educate students, employees and the community about how AIDS is transmitted, because they are in the best position to present information that may prevent unsafe sexual behavior and drug abuse among adolescents, who are hitting the age of experimentation with both sex and drugs. Seventeen percent of school-age children with AIDS got it through sexual transmission, according to the U.S. Centers for Disease Control (See Figure 1).

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The facts: the average person, says the Alan Guttmacher Institute, begins sexual activity at age 16. Some 12 million—or about 41 percent—of the nation's 25million teenagers have had heterosexual intercourse, and nearly half of 15- to 17-year-old males and one third of 15- to 17-year old females are sexually active, according to the institute, which specializes in family planning research.

And it was shown as early as 1948 in data that are still cited as

definitive today, that homosexual activity among men "is much more frequent than is ordinarily realized." (*Sexual Behavior in the Human Male*. Alfred C. Kinsey, Wardell B. Pomeroy and Clyde E. Martin, Philadelphia: W.B. Saunder Co., 1948.)

> ***"Unless you talk fairly explicitly about what is safe and what isn't safe, the translation of scientific information into what is safe doesn't occur."***
>
> ***—Jeffrey Levi, political director, National Gay and Lesbian Task Force***

In the youngest group Kinsey studied—age 15 and under—more than a quarter (27.3 percent) of the males had experienced some homosexual activity to the point of orgasm. The incidence of homosexual activity among single males rises in successive age groups until it reaches a maximum of 38.7 percent between ages 36 and 40, according to Kinsey. Thirty-one percent of those in the high school to early college years—age 16 to 20—had a homosexual encounter, as compared to 27.5 percent of those age 21 to 25, 35.8 percent of those age 26 to 30, and 33 percent of those age 31 to 35.

• • •

The Kinsey data are as true today as they were 40 years ago, said Jeffrey Levi, political director of the National Gay and Lesbian Task Force.

"There needs to be sex education. There needs to be recognition that teenage kids do a lot of experimentation both with sex and with drugs. We can't stick our heads in the sand and assume they don't do this sort of thing. The sort of sexual experimentation that goes on has nothing to do with your sexual orientation," he said.

And teaching about AIDS must include explicit details of safe and unsafe sex, or it does nothing to stop the spread of the disease, in Levi's view. "One of the things we have learned from the gay community is that unless you talk fairly explicitly about what is safe and what isn't safe, the translation of scientific information into what is safe doesn't occur. If you talk about exchanging bodily fluids, most adults don't understand what that means, much less teenagers. You have to be very specific, right down to if you don't want to catch AIDS, you must NOT do x."

Levi acknowledged that it's unlikely most schools will get that

explicit. "I know there's no way they're going to do it. The problem school administrators face, if you talk about how to have safe sex, you are teaching about how to perform sex, and you are accused of condoning it. But they have to do a cost-benefit analysis. If they want to risk the lives of thousands of teenagers just because they're uncomfortable with talking explicitly about sex," that's the decision they're going to have to make, said Levi.

It's also unlikely that most school districts—New York City is an exception—will invite members of the gay community into the schools to discuss material with which school officials may be uncomfortable. "You have to understand we are in a very difficult political position. Even though it is untrue, gays are always accused of recruiting," so school officials don't want them in the buildings, Levi said.

"You get into a small, traditional area, rural or part-rural and you'll meet a lot of resistance to regular sex education, never mind discussion of communicable diseases or gay sex."
—Herbert Margolis, attorney, Uniontown, Pa., public schools.

At any rate, few schools have added AIDS education to the curriculum. Again, New York City (as discussed in Chapter Three) is an exception to that general rule.

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In fact, given the reluctance of many communities to put sex education in the schools, educators say it's highly unlikely AIDS will ever find a place in most schools' curricula.

"You get into a small, traditional area, rural or part-rural and you'll meet a lot of resistance to regular sex education, never mind discussion of communicable diseases or gay sex," said Herbert Margolis, attorney for the 4,000-student Uniontown, Pa., public schools. "If you tried to put a course in the classroom on prevention of AIDS you'd create a furor with the community, some of which would be justified because the teachers wouldn't be qualified."

In the southwestern Pennsylvania town, a controversy erupted when parents discovered that biology and health teachers had been routinely including general information about reproduction in their classes. Those units "had gone relatively

unnoticed until the district tried to put them into a formal sex education class. So I guess the easiest way to handle it is not to call attention to it," Margolis said. The sex education course didn't make it into the curriculum.

"If you tried to compound that with AIDS education on top of that, I'm afraid you'd really have a great segment saying you're not teaching the right thing," Margolis said.

• • •

No matter what the community response, schools "absolutely must teach kids before they get to college," said Dr. Richard Keeling, head of the AIDS Task Force of the American College Health Association. "We have people coming in to us, first-year college students, they already test positive for AIDS. They were infected in high school."

> ***"We have people coming in to us, first-year college students, they already test positive for AIDS. They were infected in high school."***
>
> ***—Dr. Richard Keeling, director, Department of Student Health, University of Virginia***

That frightening fact "provides as good an argument for early sex ed as anything. You have to talk about sex itself way before high school. It's impossible for us to take high school kids who have not had any instruction in sexuality and then expect them to understand what you're talking about when you talk about AIDS. I think education about AIDS ought to start certainly in the ninth and 10th grade," said Keeling, director of the Department of Student Health at the University of Virginia.

• • •

Interestingly, many of those who don't support sex education support teaching students about AIDS—in the hopes that it will frighten students into not having sex outside of marriage.

"I think they should be warned about the incurable venereal diseases they can get," said Phyllis Schlafly, head of the conservative Eagle Forum. "They should be told not to have premarital sex at all."

Not only that, but students should be informed that

heterosexuality is the only acceptable sexual practice, say others. "I basically don't support sex education, but if there is to be sex education, I think the old fashioned values of chastity and sex with marriage, heterosexuality, should be taught," said Eileen Gardner, Murdock Fellow in Education Policy with the conservative Heritage Foundation, a Washington, D.C., think tank. "You do have to observe that what has been considered deviant behavior seems to have produced deviancy in health. There does seem to be a rather obvious link."

> ***"If there is to be sex education, I think the old fashioned values of chastity and sex with marriage, heterosexuality, should be taught."***
> ***—Eileen Gardner, Murdock Fellow in Education Policy, Heritage Foundation***

In agreement is Malcolm Lawrence, coordinator of the Maryland Coalition of Concerned Parents, a parents rights group. While opposed to sex education in schools, he sees an advantage to teaching about AIDS: "If schools insist on sticking a segment on AIDS in sex ed, I think they should point out the horrors of it, that it's fatal, a 100 percent death rate. Scare the hell out of them. Tell them it comes from promiscuous homosexual practices, also from injections with dirty needles. Tell them it's going to kill you."

Schools shouldn't make the same mistake they did with drug education, Lawrence said, where a typical class doesn't "tell you it can kill you. They'll get into values clarification and let the students decide whether to use drugs. Supposedly the classroom teacher is value- and moral-free, that's what's wrong with all these stupid courses." Scare tactics, he said, "would perhaps dissuade children from engaging in sex prematurely."

But courses should not teach safe sex techniques, Lawrence said. "You're begging the problem when you teach 10-year-olds different ways to have anal and oral sex," he said. "You're planting ideas in their heads. They are not emotionally ready to accept this as a concept. The real thing to teach is the moral and health lesson that people, prior to marriage, should say no to sex. How successful this will be I don't know. To say, use a condom, you're just giving them an escape hatch."

A curriculum that does teach about safe sex will just make kids "curious about homosexuality," added Lawrence. "According to psychiatrists, there's a little bit of homosexuality

in everybody. They might start to experiment if they learn about anal and oral sex."

* * *

Strongly in favor of adding AIDS to the school curriculum are AIDS experts, who like to use the line that "education is the only vaccine we have right now."

"Everyone is asking, 'Should kids with the virus be admitted to school?' For me an even bigger concern is how can we take the opportunity to prevent more AIDS," said Dr. Louis Cooper, director of pediatric service at St. Luke's-Roosevelt Hospital Center in New York City. "With the ticking of the clock, more people are at risk, dying, and there's not much we can do about it. The clock is also ticking on kids who currently are not infected. We have the ability to prevent the spread. It's a critical responsibility of schools and parents."

"You're begging the problem when you teach 10-year-olds different ways to have anal and oral sex. You're planting ideas in their heads." ***—Malcolm Lawrence, coordinator, Maryland Coalition of Concerned Parents***

Dr. Woodrow Myers Jr., Indiana state health commissioner, said schools and parents must get over their hangups about sexuality. "The problem is we are uncomfortable with sexuality. On the one hand, we use it to promote products. On the other hand, we're afraid to deal with it. . . . We can put it [AIDS curriculum] into schools if we can just get over our phobias about sex."

* * *

The Association for the Advancement of Health Education, which represents more than 7,000 health educators, favors teaching about AIDS in the health education curriculum, but cautions educators against rushing headlong into "crisis" education such as schools did with alcohol and drug abuse education.

"We feel that AIDS education should be a part of the comprehensive school health program and not be approached on a single subject basis," said the group's executive director, Becky Smith. "We find that typically education that is oriented toward

"We feel that AIDS education should be a part of the comprehensive school health program and not be approached on a single subject basis," said the group's executive director, Becky Smith. "We find that typically education that is oriented toward crisis-type situations is not any more productive than the typical education that's well thought out, planned, sequential, and is part of the planned curriculum of the school. I think you can understand that just to go in and do a response to a crisis is not as responsive as planning an educational curriculum."

> ***"The clock is ticking on kids who currently are not infected. We have the ability to prevent the spread. It's a critical responsibility of schools and parents."***
>
> ***—Dr. Louis Cooper, director, pediatric service, St. Luke's-Roosevelt Hospital Center, New York City***

The other side of the coin is that AIDS is a crisis and that education needs to be put into the curriculum immediately. "I don't really have a response to that, simply that it's a different educational approach," Smith said.

* * *

Some educators raise the concern that it would be difficult to teach students about AIDS when all the facts still aren't in about the disease.

"In terms of educating, we are still at the point of public education," said Phyllis Blaunstein, executive director of the National Association of State Boards of Education. "Yesterday I heard two different releases on whether AIDS could be spread by females—one saying yes, one saying it's unlikely. The medical profession, it appears, does not have its act together at all."

AIDS experts, however, think schools can take on some of the responsibilities of educating by paying attention to them, not to "Brand X experts," said Myers. "Schools should pay attention to the real experts," he said. "All of us are saying the same thing. There is no deviation. There is unanimity of opinion regarding casual contact."

Blaunstein does believe AIDS should be included in the curriculum at some point. "It probably should be immersed in sex

education, where we teach kids about decisionmaking and some basic facts about the spread of disease."

What Schools Should Do

■ Educate employees about AIDS. Try to hold small group sessions, says Bruce Schutte, senior public health educator in the AIDS unit of New York City's health department. Schutte, whose staff trained hundreds of city teachers when New York started an AIDS curriculum (see Chapter Three), says the wrong approach is to gather your staff into the auditorium to hear an expert lecture on AIDS.

■ Educate students about AIDS. If AIDS is not included in your high school curriculum, put it there. Contact your local or state health department for experts willing to help you write a curriculum, or contact educators in cities such as New York who already have written curricula. But make it a reasoned, thought-out approach; don't just decide one day that a crisis exists and an assembly must be held tomorrow. As with teachers, the small group approach works best: don't just stick 100 kids in an auditorium and show a film.

■ Educate your community about AIDS. Schools that want to go even further should extend their education into the community. As Swansea, Mass., learned (see Chapter Three), an educated community is a supportive community. This approach allows schools to start to build support in the event they ever need it.

Conclusion

Whether or not they have an existing sex education course, schools must include AIDS education in their curricula. While relatively few adolescents have developed the disease from unsafe sexual relations, AIDS experts believe many students have the virus in their blood and will develop the disease in three to seven years. Although students who fit that scenario will be out of schools' hands by then, schools have a responsibility to teach students who are not infected how to stay that way.

The need for education is even more serious in higher education, where older students and greater sexual experimentation greatly raise the chances of AIDS crises on campus. Colleges, however, are way ahead of schools in developing a cohesive response to AIDS. Chapter Seven discusses what has been done and what is still left to do on campus.

Chapter Seven

AIDS on Campus: The Higher Education Response

A male student recently came up to Dallas Bauman, director of residence life at the State University of New York at Stony Brook, and said he wanted Bauman to kick the student's two gay suitemates out of the dormitory.

"He said if they increased his chances of getting AIDS by one in a million, he wanted them out," said Bauman. "That's not only an irrational statement, it's a homophobic statement."

Yet the incident at Stony Brook is not atypical; the safety of dorm rooms is the number one AIDS query among students on U.S. college campuses.

* * *

Living in the close proximity residence halls force upon students poses no extra health hazard when it comes to getting AIDS. As demonstrated in Chapter One, living with someone with AIDS does not increase your risk of contracting the disease unless you have sex or share dirty needles with the person.

But there is no question that colleges and universities face issues elementary and secondary schools never have to confront. "College is a living environment, and our kids are older," said Sheldon Steinbach, general counsel for the American Council on Education (ACE). "The situation is changed dramatically because kids in elementary and secondary school don't live together."

Added Dr. Richard Keeling, director of the Department of Student Health at the University of Virginia and chairman of the AIDS Task Force of the American College Health Association (ACHA): "The risk to college students is greater than the numbers of college students with AIDS would indicate, because it is an experimental age. This is the time to experiment with homosexual partners, with drugs, which might have been quite

innocuous five to 10 years ago. It's certainly not uncommon for people in late adolescence to have one or two homosexual experiments." (See Kinsey data, Chapter Six.)

Keeling notes that while students may not show symptoms of AIDS during their college years, it's likely that because of AIDS' sometimes-long incubation period many people are becoming infected with the virus on campus and then developing AIDS in their mid- to late-20s.

The safety of dorm rooms is the number one AIDS query among students on campus.

Colleges have a responsibility to teach the adolescents that come to them as freshmen how to cope with life as adults, and that includes dealing with sex and sexually transmitted diseases, said Dr. Margaret Bridwell, director of the University of Maryland Health Center and president of ACHA. "That's why we've got to get the information about safe sex out there. They're in the developmental stages where they're doing a lot of experimenting, so it's up to us to get the information out there about what practices put them at risk."

To that end, ACHA has prepared a brochure about safe sex that it is distributing to campuses across the country (available for 50 cents each for 1-99 copies, 25 cents each for 100-999 copies or 20 cents each for 1,000 or more copies, prepaid or institutional purchase order, from ACHA, 15879 Crabbs Branch Way, Rockville, Md. 20855, (301)963-1100.)

"We feel like everybody in college needs to know about AIDS," said Keeling, who helped write the brochure. "There is a risk to heterosexual women whose male partners may have been experimental with homosexual men. Women should think seriously about safe sex, knowing a lot about your partner before you have sex."

The question from students,'Can I get it in the dorm?' is a very common one, said Keeling. "Well, sure, you can. You can get it anywhere, but it depends on the right kind of contact. You can do anything with a person with AIDS except have sex and do drugs."

* * *

When colleges consider their response to AIDS, they must

concentrate on the medical aspect of the disease, and resist moralizing, Keeling said. "The problem comes when you put other things into your decision that don't relate to medicine. If you approach your decision based on facts, the fact is AIDS is a sexually transmitted disease. Your response should not be to refuse to admit [students or employees with AIDS] or restrict [their] activities. The appropriate response to students is education so people don't unwittingly or unknowingly expose themselves to AIDS."

And any AIDS education must be in the context of "accepting diversity on campus," including homosexuals, said Bauman. "If the staff is homophobic, they will not be sought out as a resource. They will not be credible in AIDS education."

"College is a living environment, and our kids are older. The situation is changed dramatically because kids in elementary and secondary school don't live together."

—Sheldon Steinbach, general counsel, American Council on Education

So the right kind of education is key, and certainly not just of students. Faculty, staff and other employees, because they generally are older than students, are more likely to develop AIDS.

For that reason, and because faculty and staff need to be prepared to answer students' questions about AIDS, Maryland's Bridwell has made educating university employees her number one priority.

"I concentrate on faculty and staff," said Bridwell, who is also president of ACHA. "They have to be comfortable talking to students. On campuses, the law of averages would lead to faculty or staff [getting AIDS] first, just because they're older. We have some older students, but the greater majority of students are younger. I would suspect younger students would not be the group that would get it first."

ACHA has made educating students and staff the cornerstone of its recommendations to colleges:

> The primary response of colleges and universities to the AIDS epidemic must be education. Because there is no specific therapy for AIDS or AIDS-related conditions, the most important goals for institutions will be those of in-

creasing awareness and providing education to prevent further spread of the disease. The American College Health Association recommends that the organization and completion of effective educational programs about AIDS be an activity of the highest priority for all institutions of higher learning.

Such educational programs will address the major intervention currently possible in limiting the consequences of AIDS, which is primary prevention. They may also be of paramount importance in discharging the institution's responsibility to protect its student body and staff from the transmission of AIDS. Since the current medical evidence indicates that no actual safety risks are created in a normal academic or employment setting, the administration of effective AIDS education and training programs provides the best way for institutions to render enrollment or employment safe and healthful. The AIDS epidemic raises issues of liability that are of great concern to college and university administrators; the most effective means of addressing these issues at present is to educate students and employees about AIDS. (American College Health Association, General Statement on Institutional Response to AIDS, Dec. 2, 1985.)

College students are "in the developmental stages where they're doing a lot of experimenting, so it's up to us to get the information out there about what practices put them at risk."

—Dr. Margaret Bridwell, director, University of Maryland Health Center

The education is provided in every possible situation, from face-to-face talks between health officials and students, to training students to educate their peers, to holding day- or week-long education sessions on AIDS.

"What we've been doing here is getting out and educating as many people as we can," said Bridwell.

At Maryland, Bridwell herself goes out and talks to student, employee and community groups, explaining how AIDS works and how people can prevent its transmission. She also has groups of students who are peer educators who do contraceptive education in dormitories, fraternities and sororities; one group

has added sexually transmitted diseases, including AIDS, to its program.

Bridwell finds that waiting for people to walk in and ask about AIDS or simply advertising an AIDS seminar and waiting for people to show up does not work. Instead, she arranges one-on-one or small group sessions where attendance is more or less guaranteed. "Waiting for someone to ask to have a talk doesn't work," she said. On the other hand, "When I say, 'Gee, I'd like to come talk to you,' they say 'Come,' because they don't have to admit there's any reason they might need to hear about it."

> ***"If you're male or female, gay or straight, people in college in the 1980s no longer think it's the living-in-the-fast-lane kind of feeling. You don't hear as much of people falling into bed on the first date."***
>
> ***—Dr. Richard Keeling, director, Department of Student Health, University of Virginia***

At Virginia, Keeling's approach is similar. He runs seminars for small groups and "big public presentations" for large groups. He works with local health department physicians and counselors to develop community as well as university presentations. He works with the Gay/Lesbian Student Union on campus to spread information about risk reduction to the gay community.

Keeling speaks highly of his experience with gay student groups and recommends college officials on other campuses work with such groups as well. "The Gay/Lesbian Student Union has been tremendously responsible and responsive in organizing sessions, arranging speakers, disseminating written information. They have taken care of their own community in a way that's been very impressive to see here and at other colleges."

College officials, Keeling said, also must recognize that a good part of successful AIDS education is training leaders who will go out and be educators. That includes professional staff in student affairs offices, resident staff in dormitories, and, as at Maryland, peer educators, he said. "We have tried to educate people who will be educating other people."

The University of Virginia also has tried to help smaller colleges in the state who don't have its extensive resources. Keeling

has sent speakers to half a dozen smaller campuses in Virginia. He also suggests smaller colleges turn to their state or county departments of health for help.

* * *

Other campuses have devoted an entire day or week to the issue of AIDS, which Keeling considers a "very effective technique," but cautions that it "requires a lot of organization and effort."

> ***"If the staff is homophobic, they will not be sought out as a resource. They will not be credible in AIDS education."*** ***—Dallas Bauman, director of residence life, State University of New York at Stony Brook***

The student organizer of an AIDS week at Harvard and Radcliffe colleges agreed such events take a lot of hard work, but said they are well worth the time. In February 1986, students at the Cambridge, Mass., schools staged a week-long Festival of Life that included a kick-off gala featuring such celebrities as Colleen Dewhurst, Judy Collins and Joan Kennedy.

The week had the dual goals of raising funds for New England Deaconess Hospital and the Boston AIDS Action Committee, and raising community awareness regarding AIDS, said its organizer, Harvard senior Stephen Gutwillig.

The festival included 32 events in the arts and education: plays, concerts, films, children's events, dance, poetry readings and a week-long silent auction with donated works by professional artists. Educational events, including sessions on such topics as women and AIDS, and AIDS and law, were free. A major symposium featuring prominent scientists was scheduled so as not to conflict with any of the theatrical events.

The event cost $6,000, which came from the student government and three other campus groups, and raised about $22,000 for the action committee and the hospital, which treats more AIDS patients than any other Massachusetts hospital, according to Gutwillig. The fundraising, however, became secondary to education "when we realized the potential this event had to touch so many people," he said.

The AIDS week did not happen as the result of a crisis on campus, but rather out of Gutwillig's personal interest in seeing

something done. AIDS is not a "huge ongoing issue on this campus," he said. "We have had at this point four cases and three fatalities, including one graduate student, the rest staff. The cases haven't been publicized or sensationalized. AIDS is not the talk of the town. We were trying to primarily raise the awareness of this community as well as raise money."

Gutwillig suggests that any school can put on such an event, even without Harvard's resources or name. A core group of 15 undergraduates did most of the work, and much of the time was spent rounding up the celebrities. The event "snowballed," and although the publicity the celebrities generated helped the AIDS cause, it wasn't really necessary, he said.

An AIDS event on campus "does not have to raise money to be important. Awareness and education are key."
—Stephen Gutwillig, AIDS week student organizer, Harvard University

In Gutwillig's view, "The resources are there on any campus. You need a space and some interested people. It doesn't have to raise money to be an important event. Awareness and education are key."

* * *

As colleges get caught up in providing AIDS education in courses, seminars, days and even weeks, it's easy for them to forget that not all college students are sexually active.

College officials, while being sure they educate students about risk prevention, must be sure they present information that doesn't turn off students to whom the information does not yet—or currently—apply.

"Not only might the information go above people's heads, but they might be so offended, if they're not sexually active at all, it might annoy them and turn them off from everything you're trying to say. They might not take in your information," said Keeling.

"You must emphasize that to be active or not is their first choice, then their second choice is safe sex and contraception—but that it's a viable choice not to be sexually active. Emphasize that they have a choice, especially in an age of AIDS," he said.

Keeling and other college health officials believe the amount of sex on campus has gone way down, but say there's no way to measure it.

"To go by my impressions, impressions I have from talking to gay men, a lot of gay men are postponing sexual activity or have adopted very different patterns of sexual activity," Keeling said. "With women, certainly you can tell from their expressions of anxiety. A lot of heterosexual women who have come to see me have expressed concerns about safety, whether that translates into people doing things differently, I don't know. I certainly do have the feeling that if you're male or female, gay or straight, people in college in the 1980s no longer think it's the living-in-the-fast-lane kind of feeling. You don't hear as much of people falling into bed on the first date."

Many college officials think, "'It's not going to happen here. Our students don't do those things.'"
—Mary Elaine Perry, director of residence life, Mundelein College

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The other half of the college AIDS issue is deciding how to deal with the students and staff who inevitably will come down with the disease.

Unlike elementary and secondary schools, colleges are tending toward developing guidelines, rather than policies, to maintain flexibility. "Most schools are dealing with it on a case-by-case basis," said ACE's Steinbach. "For the most part, we've tried to discourage schools from rushing to policy statements. The situation is so fluid."

The American College Health Association's AIDS guidelines recommend that institutions "not adopt blanket policies." But they do suggest colleges allow most students who have AIDS, ARC or a positive AIDS antibody test, whether they are symptomatic or not, regular, unrestricted classroom attendance as long as they are physically able to attend class.

So far, institutions have concentrated on guidance and counseling, and on providing information, said Steinbach.

The University of Maryland, like most colleges that have dealt with the issue, is following the ACHA guidelines. "The knowledge is changing so much, I think most people think it

would be a shame to get locked into an absolute policy," said Bridwell.

Following the ACHA policy, in conjunction with the U.S. Centers for Disease Control guidelines for schools (see Appendix A), is a good idea from a legal point of view as well, according to Patricia Friend, a staff attorney at the Johns Hopkins University in Baltimore. "To a large extent your work has been done for you" by the ACHA and the CDC, she said.

Friend said any response an institution adopts, whether to an individual case or in anticipation of a case, should be a "rational response based on medical knowledge" and "be a careful balancing of competing legal issues."

The issue of trust is a key one to preventing the kind of panic elementary and secondary school officials have encountered.

If colleges follow the ACHA or CDC guidelines, Friend said, "It's reasonable to expect in any [legal] action, the decision will be upheld by a court. If the campus guidelines are more on one side or the other, the court would probably refer to CDC and ACHA as standard and put the burden on the university to explain why it deviated from them. That's not to say you couldn't explain why, but it's important to realize this."

Other college administrators watching this issue say it's not enough for higher education institutions to adopt the ACHA guidelines. Samuel Taube, assistant vice president for student affairs at the State University of New York at Stony Brook, suggested schools convene a broad-based committee, including at least administrators, health educators and physicians, to take the ACHA guidelines and decide what's best for their campus.

Schools should aim to have their recommendations validated by their president or other chief executive officer, he said, so the institution will have a policy on AIDS. "We don't want to replicate what happened in New York, or in Indiana," he said, referring to the public outcries in those two cities over admitting children with AIDS to school.

Also key is to designate one office within the institution to be responsible for keeping up with current AIDS research and recommendations. At Johns Hopkins, as at most schools that have designated such an office, that's the student health center, according to Patricia Friend.

"It seems to be the logical office on most campuses," Friend said, because that staff is best qualified to assess new medical reports on AIDS.

The role of a university's general counsel, in whose office Friend works, should be "pretty limited. If the school is handling these cases based upon all the information available to them and the action is reasonable, a lot of the work of the general counsel has been done. We're keeping an eye out for defensible behavior on the part of administrators. As long as administrators act reasonably, we basically just monitor them periodically," she said.

Colleges should adopt a "rational response based on medical knowledge" that carefully balances "competing legal issues."
—Patricia Friend, staff attorney, the Johns Hopkins University

Johns Hopkins has not had AIDS cases "that we know of," said Friend. While the school has only 2,400 students, it's still "hard to say if we would know here." Under student health center policy, the campus at large and even the general counsel's office would not know about any disease unless public health concerns existed, she said. "A lot of people question that. If we were dealing with chicken pox, we probably would know about that. But at this point, current knowledge about the disease [AIDS] doesn't really require that it go beyond the health center and you have privacy concerns at that point if it did go beyond the health center."

A similar story is told at the University of Maryland, where the student health center is also the campus office that keeps up with current medical knowledge about AIDS. At the significantly larger (30,000-student) campus, there are also no cases "that we know about," said Bridwell. "And I wouldn't tell you if we did have a case because of the confidentiality issue."

Bridwell said a student with AIDS could easily remain undiscovered at a large university like Maryland. "Somebody who self-reports knows that there will be some kind of uproar," she said.

If an AIDS case was reported on campus, "there would be somewhat of a scare," said Paul Kirby, assistant news editor of the University of Maryland student newspaper *The Diamond-*

back. "People would think, 'Did I come into contact?' and so forth."

But "Bridwell would try to explain the situation. We would do stories," he said. And everything would work out because "people would believe her. They trust her," Kirby said.

The issue of trust is a key one to preventing the kind of panic elementary and secondary school officials have encountered among parents.

> ***"I wouldn't tell you if we did have a case [of AIDS] because of the confidentiality issue."***
>
> ***—Dr. Margaret Bridwell, director, University of Maryland Health Center***

"Obviously if you had a health administrator who was not trusted, it would be a problem," said Stephen D. Blom, executive director of the American College Health Association. "Particularly in working with students, they are very idealistic, they want to hear the truth. Students are usually a pretty rational and reasonable group, if you're honest with them."

Trust is also a key issue when it comes to confidentiality. While they oppose mandatory screening, the ACHA guidelines recommend that new students with AIDS voluntarily identify themselves to the student health center so they can receive "proper" care and education.

That suggestion is "very risky," said Stony Brook's Taube. "The potential for violating an individual's rights is very high."

* * *

While colleges are way out front of elementary and secondary schools in terms of a well-thought-out response to the AIDS issue, many schools don't think they need to act on the issue. Mary Elaine Perry, director of residence life at Mundelein College, a small Catholic women's school in Chicago, interviewed dozens of college officials on AIDS in preparation for a presentation at an April 1986 conference of the National Association of Student Personnel Administrators.

"I got a wide range of responses. Many said, 'It's not going to happen here. Our students don't do those things,'" said Perry. Others, of course, were at the opposite end of the spectrum, with task forces and policies and lots of education going on.

At her institution, the students are mainly concerned for their male friends. Wrongly, "they're not concerned for themselves," she said. At some religious institutions, Perry found the attitude: "This is a fine religious institution. No way could this happen here." At other institutions, a task force has made recommendations, but the president or vice president is "sitting on a policy," she said.

But Perry was optimistic. Most schools she spoke to, Perry said, realized the need for education.

One school that did successfully convene an AIDS task force and put a policy in place—even though it's outside the high-frequency AIDS states—is Iowa State University.

CASE STUDY: IOWA STATE UNIVERSITY

At Iowa State University, top campus officials in late 1985 decided the time was right to form a task force on AIDS.

The student government's goal is "to educate students on the issue [of homosexuality] in general, to open the communication lines."

—John Reiher, vice president, Government of the Student Body, Iowa State University

"Last fall, there was so much hysteria circulating, we felt the need to have some policy in place prior to having to deal with someone with AIDS," said Dr. Robert Patterson, director of the Student Health Center and chairman of the AIDS Task Force at the Ames, Iowa, campus.

Why hysteria at a midwestern campus in a state that ranks 39th in the number of reported AIDS cases nationwide?

"People have fears no matter where they live," said Patterson. Agreed Thomas Thielen, the university's vice president for student affairs: "There's a lot of ignorance in society about AIDS."

Thielen, who formed the task force after hearing a presentation on AIDS at a Washington, D.C., meeting of the National Association of State Universities and Land-Grant Colleges, said he was "really alert to the question, 'Are we making more of this than we should?'"

But after hearing the presentation by Dr. Richard Keeling, Thielen returned to Iowa convinced the university—midwest locale or not—needed a policy on AIDS.

"We didn't do this because we have any known victims or anything like that, we just thought it would be best to take a look at it," said Thielen. "We know we will not be immune." Patterson echoed that, saying it is "prudent" to expect that, because of the spread of the disease, Iowa State eventually will have to deal with AIDS in students or employees.

> ***"I think should we be faced with certain circumstances, there would be a lot of screaming and hollering. I think people's bad sides would show, but at least the university has already decided how it would work."***
>
> ***—Dr. Robert Patterson, director, student health center, Iowa State University***

And Patterson was convinced students needed to be better informed: he had been getting questions like, "If there were a case in the dorms, would it be safe to use the public drinking fountains?"

* * *

So Thielen asked Patterson to head the task force, made up of 17 representatives of all facets of the university: residence life, student health, personnel, dean of students, student counseling, student government, gay and lesbian community, the community of Ames and so forth.

The group broke into two committees: one to look into developing an AIDS policy for the university and one to look into developing an education program about AIDS.

Instead of a policy, the panel in January 1986 presented Thielen with guidelines that stress "flexibility in responding to its concern for individual as well as community welfare."

The guidelines, which the university adopted the following month, prohibit discrimination against students and employees with AIDS (see Figures 8 and 9). They forbid the university from revealing names of students or employees with AIDS and university employees from inquiring into the sexual preference of a student or an employee. They call for a three-member team to make case-by-case decisions on whether a student with AIDS should attend classes or participate in university activities.

The guidelines also set out procedures for specific employee groups regarding AIDS: food service, custodial and health care workers, occupants of university housing, health and nutrition educators and researchers, and athletic coaches.

For food service workers—target of much of the misplaced fears about casual transmission of AIDS—the guidelines call for no restrictions unless the employees have other illnesses for which restriction would be warranted. They note that good hygiene for everyone is the key: "Food tainted with blood must be discarded whether or not the handler is infected with AIDS virus."

* * *

On the education side, the task force made a packet available to professors who want to have a short unit on AIDS, "giving a perspective on what the problem is, the risks of acquisition, and prevention," said Patterson. The subject lends itself to many courses in a typical college curriculum, he said, because AIDS is not just a health problem. "It's a social problem as well. I see it [a unit on AIDS] being given in a number of different disciplines within universities, because it's a fascinating sociologic phenomenon."

The packet Patterson gives professors is not a written curriculum, but rather resource material and a bibliography to guide them in the right direction. The professor then decides what track to take within each discipline and class.

Education at Iowa State, as on any campus, is hardly limited

Figure 8
Iowa State University
Guidelines For Personnel

A. Routine screening of employees for AIDS virus (HTLV-III/LAV) is not recommended. Screening for AIDS virus infection shall not be a requirement for employment eligibility.

Figure 8 (Cont.)

B. An employee's medical diagnosis is personal information and such information, if known, shall not be released without the employee's permission, except as otherwise provided by law.

C. Sick leave and leave of absence shall be granted to all employees with illnesses, including AIDS, according to the standard university procedures for granting such leave.

D. The university shall provide reasonable accommodation to employees with AIDS as with any other disability or handicap. The determination of whether an AIDS virus-infected employee should be permitted to remain engaged in normal work activity shall be made on a case-by-case basis by a team composed of the employee and/or his/her representative, the employee's physician and appropriate university personnel.

E. In all cases of illness, including AIDS, management will not request a diagnosis of illness, except as required for accommodation or medical disability claims. As appropriate, the employee may be asked to provide a physician's certification of ability or inability to work or amount of time needed for recuperation.

F. The sexual orientation of an employee shall not constitute reasonable cause to believe that he/she has AIDS virus infection. No employee or potential employee shall be asked to provide information as to his/her sexual orientation.

G. The university shall provide education and information about AIDS and its transmission to concerned employees. Refusal to work with a person infected with AIDS virus does not excuse an employee from fulfilling assigned responsibilities and such refusal can result in disciplinary action. No special consideration should be given beyond normal transfer requests for employees who feel threatened by a co-worker's illness.

Source: Iowa State University

Figure 9
Iowa State University
AIDS Guidelines For Students

A. Students diagnosed as having AIDS, or with laboratory evidence of infection with AIDS virus (HTLV-III/LAV), and receiving medical attention should be permitted to attend classes and utilize university services in an unrestricted manner.

B. The determination of whether an infected student should not be able to attend classes or participate in university activities shall be made on a case-by-case basis by a team composed of the student and/or his/her representative, the attending physician and appropriate university personnel.

C. If an infected student is not permitted to attend classes or participate in university activities with other students, the university shall either make reasonable effort to provide the student with an adequate alternative educational opportunity, or an unconditional withdrawal from the university.

D. The identity of an individual known or reasonably suspected to be infected with AIDS virus shall not be publicly revealed by the university.

E. The sexual orientation of a student shall not constitute reasonable cause to believe that he or she is an infected individual. No student shall be asked to provide information as to his or her sexual orientation.

F. Routine screening of students for HTLV-III/LAV viral infection is not recommended. Screening shall not be a requirement for university attendance.

G. Continuing education of university students should ensure that proper and current information about AIDS is available.

Source: Iowa State University

to the classroom. Most of the educating about such issues as AIDS goes on in less formal settings.

"The education will mainly be to student and university employee groups and to the community," said Patterson. The Student Health Center, which Patterson runs, will increase its efforts to present information about AIDS and other sexually transmitted diseases to student, employee and community groups. Members of the Gay and Lesbian Student Outreach's Speakers Bureau are available for presentations. And existing channels for student education, such as dormitory floor meetings, will be used as an avenue for programs on AIDS.

"Most students are supportive. The more ignorant ones are not."
—President, Gay/Lesbian Student Organization, Iowa State University

* * *

While the policy was being formed, it attracted a great deal of local and statewide publicity and, although university officials agreed that AIDS should not be primarily a gay issue, the publicity caused many students to think about the issue of homosexuality, and not always with positive results.

"My sense is that it [homophobia] probably has increased," said Thielen. "Although AIDS is not mentioned, the area of gay students' rights has been in the student newspaper more often in the last few months. I think it has brought it to the forefront a little more, probably not for all the right reasons."

A controversy has erupted over student government funding for the Gay/Lesbian Student Organization's educational outreach program, and there is speculation that publicity over the AIDS guidelines spurred student sentiment against the group and homosexuals in general.

"Most students are supportive. The more ignorant ones are not. They're against giving us money. A lot of students are angry that we are being allocated any money," said the president of the Gay/Lesbian group, who asked not to be named because her parents and employer do not know she is gay. "There is a lot of ignorance about the disease. People are saying, 'Aren't you afraid of getting it?' The heterosexual people look at gay people's dating as promiscuity. The average gay man will say, 'I'm no more promiscuous than you are in your dating.'"

The Government of the Student Body, a student-elected group that makes the funding decisions, she noted, has given the group the money, "so they must think that what we are doing is credible."

The Student Health Center will increase its efforts to present information about AIDS and other sexually transmitted diseases to student, employee and community groups.

Indeed, the student government "looks upon this group as providing an educational service to students," according to its vice president, John Reiher. "That's our main goal, to educate students on the issue [of homosexuality] in general, to open the communication lines. It seems whenever there is an issue people don't know much about, there is prejudice. I don't sense a lot of open and outward prejudice, but I do believe many people are prejudiced."

Reiher, who represented the student government on the AIDS Task Force, said the funding controversy comes up every year—the group has received several hundred dollars annually for the past four years—and is unrelated to the Task Force's work. In fact, he thinks the task force's work has not affected students' prejudices either way, neither making them more understanding of homosexuality nor stirring up prejudice.

"I don't think the task force has had any effect whatsoever [on student attitudes]. The task force was done more as a university administration function for them to be able to follow in case a student or staff member contracted AIDS and had some problems. I don't think students in general connected the university writing an AIDS policy and a homosexual student group," Reiher said.

Thielen said he has heard nothing but praise for the task force's efforts.

"When we began this, we expected some concerns and issues. . . . I expected some negative reaction to a fairly liberal stance we're taking. As of now, I've not received any. I've received a couple of letters commending the stance we're taking, that an AIDS victim be allowed to remain here if his or her health condition merits it."

• • •

So far, the process of coming up with guidelines "has helped put people's minds at ease that you can't catch AIDS through casual contact," Patterson said.

Noncasual contact, he said, may be down as well, though it may be too much to attribute that to one set of guidelines. "I think that certainly recent epidemics of sexually transmitted illnesses, herpes and now AIDS, are changing people's sexual habits. They're being more selective. I don't know that there's any less sex, but there are fewer numbers of people involved."

But the real test will come should there be an AIDS case reported on campus. The Iowa administrators are realistic.

"I have to be optimistic," said Patterson. "I think, should we be faced with certain circumstances, there would be a lot of screaming and hollering. I think people's bad sides would show, but at least the university has already decided how it would work."

The real test will come should there be an AIDS case reported on campus.

Thielen's prediction was similar: "Human nature being what it is, if the news became fairly public, I'd say there'd be pressure to remove that person, isolate that person. Based on our guidelines, we'd only do that if the medical diagnosis told us we should do that. But we'd get pressure internally and externally to isolate the person."

Reiher believes a student with AIDS would have an easier time than a professor because faculty members are always in the limelight. "If it were a faculty member, we would have some students who would be quite worried about it. We would get some press about students who don't want to attend class. It would be easier for a student to protect himself from the masses, than a professor who has to face 200 students a week."

* * *

What would Thielen recommend to other university officials considering starting such a process?

"I just think it's something that one needs to address in a fairly calm and serene way before you get into the eye of the hurricane. When that happens, I'm not sure all of our fine

guidelines will help us. There is an element of hysteria surrounding this."

While few colleges have gone through the process Iowa State experienced in 1985-86, it's likely more will do so as their administrators—like Iowa's Thielen—return from higher education conferences that provoke them into thinking about AIDS.

Most higher education conferences held in 1986 are including at least one session on AIDS. The brochure that advertised the spring ACHA conference touted an all-day colloquium on AIDS, saying, "The sudden emergence of a serious health problem—AIDS—has brought college health services into prominence in recent months."

What all this means is that AIDS is being billed as the number one health problem facing colleges, and "that's the thing that is so interesting to me," said Bridwell. "It shouldn't be the number one problem. It's a nonproblem [because of the small numbers] that has become a tremendous problem."

What Colleges Should Do

- Educate your employees and students about AIDS, through one-on-one meetings, small-group seminars and larger, campus-wide events. "You have to educate everyone, if they're in a risk group or not," said Keeling.

- Concentrate on training those who will have the most impact on others, whether on your campus that means student affairs staff, residence hall staff, student government leaders or student newspaper editors. It goes without saying that your student health staff should be well-trained.

- Don't mince your words. Be straightforward about what practices are safe, and which ones are unsafe. But be sure to remember that not all students are sexually active, and let them know that's okay.

- Work with gay student groups on your campus. They are likely already to be well-educated on AIDS.

- Come up with a policy on AIDS, and get it approved by your president or chief executive officer. Start with the ACHA guidelines (available in book form for $7.50 prepaid or institu-

tional purchase order from the ACHA, 15879 Crabbs Branch Way, Rockville, Md. 20855, (301)963-1100) and adapt them to fit your campus's needs.

■ Appoint one office within the university to coordinate your AIDS activities. The office should keep up with the latest research from the Centers for Disease Control, plan education programs for the campus, and be available if students or staff have questions on AIDS.

Conclusion

Much of this book has concentrated on AIDS and the public schools, and most of the headlines *have* been about schoolchildren with AIDS. Colleges have stayed out of the headlines, in part because they've been better prepared and in part because college students or employees aren't necessarily letting anyone know about their illness. ACHA and the American Council on Education have been way out front in trying to forestall the kinds of crises happening in schools from making their way to a college campus.

"I have not heard of any problems," said Maryland's Margaret Bridwell. "Cases have been handled on an individualized basis with hardly any furor. What has been done has been done with a degree of sensitivity to the stricken individual and with at the same time a substantial eye out to protect the rest of the college and university."

But higher educators have not really been tested yet. The news media could latch onto a college student or employee with AIDS as they did with Ryan White, and the best defense is to be prepared with a policy and a well-educated community.

"I'd like to avoid on campus what we see elsewhere," said Keeling, referring to the panics many communities have had over AIDS. "Ethically, we need to consider the rights of all groups on campus. Whether people in college are gay or straight, male or female, black or white, everyone needs to know about AIDS, no one needs to be panicked about AIDS, and we need to get on, as educators, to educate and stop the spread of AIDS."

Conclusions and Recommendations

AIDS is a very serious disease—for which there is as yet no cure—and no school official should brush off that fact. But AIDS does not spread through the kind of casual contact most children and employees have with each other in school, and *that's* the central fact for school administrators to keep in mind as they develop policies to deal with AIDS.

The older the students get, however, the more crucial it is for school and college officials to put a great deal of time and effort into education, to prevent the spread of the disease through the non-casual contact that *does* cause AIDS to spread: sexual activity and intravenous drug use.

This book has spotlighted ways schools can deal with AIDS, from developing AIDS policies to setting up AIDS curricula. Ten specific recommendations are offered here to further help schools cope with the complex issues AIDS brings.

• • •

1. Learn everything you can about AIDS. Familiarize yourself with the CDC guidelines (see Appendix A) and your state or local guidelines, and keep up with the ongoing research on AIDS.

2. After you've completed your research, work with your state or local health department and members of the school community to come up with an AIDS policy *before* you have to deal with an AIDS case.

3. Consult with your school attorney to make sure your policy is legally defensible. Policies that aim for wholesale exclusion of students or staff with AIDS are unlikely to pass muster. Best is a case-by-case approach that leans toward including students and employees in school based on team decision-making.

4. Set up basic hygiene standards for handling blood and other body fluids of all children and employees, not just those with AIDS.

5. Educate the community about AIDS, and involve them in

your general decisionmaking on AIDS policies. But limit knowledge about individual cases to only those who truly have a need to know.

6. Keep control of the situation. Make an informed decision and stick with it. Listen and respond to community concerns, but don't be swayed by *uninformed* public opinion.

7. Designate a certain person or office—perhaps the school nurse or campus health center—to keep track of information on AIDS. If you do end up with a public situation, appoint one or two spokespersons with authority to speak for the school. Either way, set up a broad-based panel to handle the case-by-case decisions on AIDS patients.

8. Train your employees to deal with AIDS in the curriculum and in informal settings. Call in an expert and plan small group sessions to effectively impart the complex information about AIDS to your staff.

9. Educate your students. For schools, that means including AIDS in your high school and junior high school curricula. Contact your local or state health department or other schools who have already dealt with the issue for experts willing to help you write a curriculum. For colleges, that means making information available to professors who want to discuss AIDS in their courses and it means planning education programs that will touch as many people on campus as possible.

10. And, most important, if you do end up having students or employees with AIDS in school, treat them like anyone else. Once your legal and medical experts have assured you that the AIDS victims can stay in the classroom, don't make them feel like outcasts by excluding them from school activities.

• • •

School officials can't do anything to cure AIDS or to ease the physical suffering of those with the disease. But they can ease the psychological pain that accompanies a terminal illness by allowing students with AIDS to continue and complete their education, or by allowing employees with AIDS to continue their careers.

And they can contribute toward easing the spread of the disease through what they do best: education. With the right kind of education, say AIDS experts, we could stop the spread of the disease tomorrow.

APPENDIX A

Centers For Disease Control Recommendations For The Education And Foster Care Of AIDS-Infected Children August 1985

The information and recommendations contained in this document were developed and compiled by the Centers for Disease Control (CDC) in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem. As of August 20, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among

children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia and Puerto Rico, with 75 percent residing in New York, California, Florida and New Jersey.

Table 1. Provisional Case Definition For Acquired Immunodeficiency Syndrome (AIDS) Surveillance Of Children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and

2. No known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be excluded.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.

2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S. C. 1232g. and employee right-to-know statutes for public employees in some states.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring HTLV-III/LAV Infection and Transmission. In adults and adolescents, HLTV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from blood, semen, saliva and tears, but transmission has not been documented from saliva and tears. Adults at increased risk of acquiring HTLV-III/LAV include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products and sexual contacts of persons with HTLV-III/LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period. In utero or intrapartum

transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk. Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring HTLV-III/LAV infection; 20 percent of the cases occurred among children who had received blood or blood products, and for 10 percent, investigations are incomplete.

Risk of Transmission in the School, Daycare or Foster-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, daycare, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission.

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or daycare setting than a home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be ex-

pected to be at greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex and measles. Assessment of the risk of the immunodepressed child is best made by the child's physician, who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach, including the child's physician, public health personnel, the child's parent or guardian and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

2. For most infected school-age children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school daycare and to be placed in a foster home in an unrestricted setting.

3. For the infected preschool-age child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-

III/LAV infection and the modes of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.

5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and daycare facilities, regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted one part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.

7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.

8. Adoption and foster care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations

of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.

9. Mandatory screening as a condition for school entry is not warranted based on available data.

10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

For more information, contact Centers for Disease Control, 1600 Clifton Road, Bldg. 6, Room 277, Atlanta, Ga. 30333.

Source: Morbidity and Mortality Weekly Report, Aug. 30, 1985

APPENDIX B

Centers For Disease Control Recommendations For Preventing The Transmission Of AIDS In The Workplace, Including Schools November 1985

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does not recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needle-stick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III/LAV infection and children born to infected mothers. HTLV-III/LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components and perinatal transmission from mother to neonate. HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk and urine and is likely to be isolated from some mother body fluids, secretions and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs and for dental-care personnel and persons performing necropsies and morticians' services. Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV

transmission in prisons, other correctional facilities and institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers.

HTLV-III/LAV-infected individuals include those with AIDS; those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through sexual contact, parenteral exposure to contaminated blood or blood products and perinatal transmission from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water or airborne or fecal-oral routes.

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace.

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per milliliter of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients.

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III/LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6 percent to 30 percent, far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1 percent. In addition, all HCWs who have been shown to transmit HBV infection in health care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per milliliter) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting. The HBV model thus represents a "worse case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids and items soiled with blood or other body fluids.

TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologies and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers and others whose work involves contact with patients, their blood or other body fluids or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students and house staff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk of transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk of HCWs acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (44.5 percent) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS. Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection, neither had a pre-

exposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient.

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace. These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely.

1. Sharp items (needles, scalpel blades and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.

2. Disposable syringes and needles, scalpel blades and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes or otherwise manipulated by hand.

3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.

4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags or other ventila-

tion devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if an HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for preventing HTLV-III/LAV transmission.

Precautions for HCWs during home care of persons infected with HTLV-III/LAV. Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission. HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposure to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care. Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposures of HCWs. If an HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologicaly to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after six weeks and on a periodic basis thereafter (e.g., three, six and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service

(PHS) recommendations for preventing transmission of AIDS. If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients. Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients. Since the experience with infected patients varies substantially among hospitals (75 percent of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS

Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open

tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients. These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients; and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of an HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs. Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV. HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular

concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents. The HCWs' personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

STERILIZATION, DISINFECTION, HOUSEKEEPING AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV-III/LAV

Sterilization and disinfection procedures currently recommended for use in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments of other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before re-use. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice. When decontaminating instruments or medical devices, chemical germicides that are registered with, and approved by, the U.S. Environmental Protection Agency (EPA) as

"sterilants" can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M St. SW, Washington, D.C. 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide. Concentrations ranging from 5,000 ppm (a 1 to 10 dilution of household bleach) to 500 ppm (a 1 to 100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste are adequate for disposal of waste contaminated by HTLV-III/LAV.

Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

CONSIDERATIONS RELEVANT TO OTHER WORKERS

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus, and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principals of good hygiene, antisepsis and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in

health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs). FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation. All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones,

office equipment, toilets, showers, eating facilities and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights and employee right-to-known statutes.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National

Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

For more information, contact Centers for Disease Control, 1600 Clifton Road, Bldg. 6, Room 277, Atlanta, Ga. 30333, (404)329-3472.

Source: Morbidity and Mortality Weekly Report, Nov. 15, 1985

APPENDIX C

National Education Association Recommended Guidelines For Dealing With AIDS In The Schools October 1985

Every school district, college and university should establish guidelines for dealing with the problems presented by students and school employees who have or could transmit AIDS to other student or school employees.

The recognized employee organization should be involved in the development of these guidelines, and any dispute as to their meaning or application should be subject to the appropriate grievance/arbitration procedure. The guidelines should be reviewed periodically, and revised as necessary to reflect new medical information regarding AIDS.

On the basis of presently available medical information, the National Education Association recommends the following guidelines (the terms "infected student," "infected school employee," and "infected individual" are used in these guidelines to apply both to persons who have been diagnosed as having AIDS and to persons who are "asymptomatic carriers," i.e., those who have been infected by the AIDS virus and are capable of transmitting it but who have not developed any of the symptoms of AIDS):

1. (a) Infected neurologically handicapped students who lack control of their bodily secretions, or who display behavior such as biting, vomiting, etc.[1] and infected students who have uncoverable, oozing lesions, shall not be permitted to attend classes or participate in school activities with other students.

(b) The determination of whether an infected student who is not excluded pursuant to Section 1(a) above shall be permitted to attend classes or participate in school activities with other students shall be made on a case-by-case basis by a team composed of public health personnel, the student's physician, the student's parents or guardian and appropriate school personnel, which

shall include the infected student's primary teacher(s). In making this determination, the team shall consider: (1) the behavior, neurological development and physical condition of the student; (2) the expected type of interaction with others in the school setting; and (3) the impact on both the infected student and others in that setting.

(c) The determination of whether an infected school employee should be permitted to remain employed in a capacity that involves contact with students or other school employees shall be made on a case-by-case basis by a team composed of public health personnel, the school employee's physician, the school employee and/or his/her representative, and appropriate school personnel. In making this determination, the team shall consider: (1) the physical condition of the school employee; (2) the expected type of interaction with others in the school setting; and (3) the impact on both the infected school employee and others in that setting.

2. (a) If a school employer has reasonable cause to believe that a student or school employee is an infected individual,[2] the school employer may require said individual to submit to an appropriate medical evaluation.

(b) The sexual orientation of a student or school employee shall not constitute reasonable cause to believe that he or she is an infected individual. No student, school employee or potential school employee shall be required to provide information as to his or her sexual orientation.

3. (a) If an infected student in grades kindergarten through 12 is not permitted to attend classes or participate in school activities with other students, the school employer shall make every reasonable effort to provide said student with an adequate alternative education. To the extent that this requires personal contact between the student and school employees, only those school employees who volunteer shall be utilized.

(b) If the employment of an infected school employee is discontinued, said school employee shall be entitled to use any available medical leave and receive any available medical disability benefits.[3]

4. A school employee shall not be required to teach or provide

other personal contact services to an infected student, or to work with an infected school employee, unless a determination has been made pursuant to Section 1 above to permit said individual to remain in the school setting. NEA and its affiliates shall provide appropriate legal assistance to any school employee who is subjected to adverse action by a school employer because he or she refuses to teach, provide personal contact services to, or work with, an infected individual, or an individual who there is reasonable cause to believe is an infected individual, unless a determination has been made pursuant to Section 1 above to permit said individual to remain in the school setting.

5. The identity of an infected individual or an individual who there is reasonable cause to believe is an infected individual shall not be publicly revealed. If an infected individual is permitted to remain in the school setting after a determination has been made pursuant to Section 1 above, school employees who are likely to have regular personal contact with said individual shall be informed of his or her identity by the school employer, and provided with appropriate information as to said individual's medical condition, including information as to any factors that might warrant a reconsideration of whether he or she should be permitted to remain in the school setting.

[1] This refers to infected students who suffer from a disorder of the nervous system that is the cause of the indicated symptoms.

[2] "Reasonable cause" would exist, for example, if the spouse of a school employee has AIDS or if a school employee recently has given birth to a child who has AIDS.

[3] NEA affiliates should review their state retirement systems and other disability income programs and, if necessary, seek to amend them to provide appropriate coverage for school employees who have AIDS.

For more information, contact the National Education Association, 1201 16th St. NW, Washington, D.C. 20036, (202)833-4000.

APPENDIX D

American Federation Of Teachers
Policy Statement On
School Policies To Control The Spread
Of Contagious And Infectious Diseases
October 1985

The emergence of Acquired Immune Deficiency Syndrome (AIDS) as a major public health concern raises the larger question of the degree to which school districts throughout the nation are fulfilling their obligations to protect their students, personnel and communities from the spread of contagious and infectious diseases. An effective and responsible approach to safeguarding the health of students and school personnel requires that legitimate concerns about the potential for the transmission of diseases in school settings neither be sensationalized nor minimized, but that school officials work closely with other interested parties to establish policies and procedures that inhibit the likelihood of contagion while promoting an educational environment characterized by safety, continuity and calm.

While the Centers for Disease Control recommendations for the education of children with AIDS provide a reasonable basis for making policy on the local level, the American Federation of Teachers proposes the following supplementary guidelines for use by school districts and AFT local affiliates in the development of procedures for the control of contagious and infectious diseases.

1. All school district policies and procedures for the control of contagious and infectious diseases should reflect consultation with designated employee representatives, public health officials, parents and appropriate community agencies and organizations. Such policies should include clear written criteria for establishing the circumstance under which students or school personnel may be required to obtain independent medical evaluations for the purpose of determining the presence of contagious or infectious diseases. District policies also may include the requirement that school personnel, as well as the parents of

affected children, notify appropriate school officials upon receiving a diagnosis confirming the presence of contagious or infectious disease.

2. The necessity for exercising special precautions or restrictions involving individual teachers or support staff with contagious or infectious diseases should be determined entirely on medical grounds, on a case-by-case basis, pursuant to the district's written policies. Teachers or support staff shall not be deprived of due process in connection with decisions resulting in the exercise of special precautions, restrictions or the interruption of employment.

3. Decisions regarding the appropriate educational setting, as well as the need for special precautions or restrictions, for students with contagious or infectious diseases should be made on a case-by-case basis, using a professional team approach. In the case of elementary schools, the student's teacher and school nurse, as well as paraprofessionals and support personnel with whom the student comes into frequent contact should be included on the professional team. The child's health status, behavior, neurological development, physical condition and expected interaction with others should be considered in determining appropriate educational placements.

In junior and senior high schools, at least one of the student's teachers should serve as a member of the professional team, and each of the student's teachers should be assured the opportunity for consultation in the determination of an appropriate educational setting and the necessity, if any, for special precautions or restrictions.

4. The district should provide an appeals mechanism for parents who disagree with placement decisions involving students with contagious or infectious diseases. Affected teachers, paraprofessional and support personnel who disagree with professional team decisions regarding classroom placements of students should be provided the opportunity to appeal and to request transfer to another assignment. School personnel shall not be deprived of due process or grievance rights in connection with such decision or appeals.

5. Based on current available medical research, mandatory

screening for AIDS should not be required for teachers, school personnel or students.

6. Children with contagious or infectious diseases for whom classroom attendance is impermissible should receive appropriate alternative instruction.

7. Teachers and staff who are unable to continue their employment on account of contagious or infectious disease should be eligible, upon medical determination and certification, to receive medical disability retirement or comparable compensation, including continuation of health insurance coverage.

8. School districts must provide physical environments conducive to good public hygiene and health, including sufficient nursing and maintenance personnel; sanitary food handling, toilet and shower facilities; adequate and readily accessible supplies of soap, disinfectant and protective outerwear (including rubber gloves); hot water and plumbing in good repair; and proper receptacles for the disposal of contaminated materials, refuse and waste.

9. School systems should provide students and staff with instruction in the epidemiology of contagious and infectious diseases, modes of transmission, precautionary measures and principles of good physical hygiene. Health educators and school nurses should be included as valuable resource personnel in the development and delivery of such instructional programs.

The American Federation of Teachers further calls upon government at every level to provide sufficient resources for research, treatment, and public health programs to control the spread of contagious and infectious diseases. The AFT particularly commends the United States Congress for having increased funding for AIDS-related research activities.

On the national and local levels, the American Federation of Teachers will continue to work closely with its affiliates, governmental agencies, public health authorities and other appropriate organizations in efforts to make schools and their surrounding communities safe from the spread of contagious and infectious diseases.

For more information, contact the American Federation of

Teachers, 555 New Jersey Ave. NW, Washington, D.C. 20001, (202)879-4400.

Source: American Federation of Teachers

APPENDIX E

National Association Of Independent Schools
Statement On AIDS
November 1985

In recent weeks the National Association of Independent Schools (NAIS) has received numerous inquiries from member schools reflecting the national concern about AIDS. So far we know of only one actual incidence of the disease in a member school, but the potential implications are significant as the disease spreads. Currently the U.S. Public Health Service projects a doubling of the cases from over 14,000 to approximately 28,000 within the next twelve-month period.

The Executive Committee of the NAIS Board of Directors has approved the following guidelines (originally proposed by the NAIS Academic Services Committee) for consideration by member schools as they confront the possible occurrence of AIDS among students, faculty or staff:

1. Students need accurate information about AIDS—its causes, its effects and its prevention. Such information should be provided by schools and included in any health, drug or sex education course.

2. Schools should establish policies and procedures to deal with the victims of AIDS on a case-by-case basis before such action is necessary. The discussion of these policies and procedures should involve public and school health officials, parents, faculty, trustees and administration, and legal counsel. A school's response to AIDS should reflect consideration of the needs of its families and students as well as the needs and purposes of the school.

3. If a student or a faculty member with AIDS continues to participate in the school, the school must provide the necessary support. Similarly, the school should consider how best to demonstrate its continuing concern for students, faculty or staff members with AIDS who must be excluded from the school.

4. In all respects, as a school responds to AIDS and its victims it has a responsibility to combat hysteria, fear, prejudice and misinformation.

For more information contact the National Association of Independent Schools, 18 Tremont St., Boston, Mass. 02108, (617)723-6900.

Source: National Association of Independent Schools

APPENDIX F

State Of Connecticut
Guidelines For Providing Education
To Students With AIDS
January 1985

The following guidelines for local school districts have been prepared by the Joint Task Force on Educating Children with Pediatric Acquired Immune Deficiency Syndrome (AIDS) and its related complex (ARC). These guidelines are intended to provide districts with a suggested framework on which to develop programs which meet the needs of all children for whom the public schools are responsible.

Since AIDS and milder immune deficient syndromes associated with AIDS virus infection, e.g. ARC, are transmitted through intimate sexual contact or blood to blood contact, children with either AIDS or ARC should not pose a health risk to other children or staff in a school setting.

1. All children in Connecticut have a constitutional right to a free, suitable program of educational experiences.

2. As a general rule, a child with AIDS/ARC should be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges and services provided by law and local policy of each school district.

3. The school nurse should function as (a) the liaison with the child's physician, (b) the AIDS/ARC child's advocate in the school (i.e., assist in problem resolution, answer questions) and (c) the coordinator of services provided by other staff.

4. The school should respect the right to privacy of the individual, therefore knowledge that a child has AIDS/ARC should be confined to those persons with a direct need to know (e.g., principal, school nurse, child's teacher). Those persons should be provided with appropriate information concerning

such precautions as may be necessary and should be aware of confidentiality requirements.

5. Based upon individual circumstances, including those discussed below, special programming may be warranted. Special Education should be provided if determined to be necessary by the Planning and Placement Team.

6. Under the following circumstances a child with AIDS/ARC might pose a risk of transmission to others: if the child lacks toilet training, has open sores that cannot be covered, or demonstrates behavior (e.g., biting) which could result in direct innoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist, the school medical advisor, in consultation with the school nurse and the child's physician, must determine whether a risk of transmission exists. If it is determined that a risk exists, the student shall be removed from the classroom.

7. A child with AIDS/ARC may be temporarily removed from the classroom for the reasons stated in #6 until either an appropriate school program adjustment can be made, an appropriate alternative education program can be established, or the medical advisor determines that the risk has abated and the child can return to the classroom.

(a) A child removed from the classroom for biting or lack of toilet training should be immediately referred to the Planning and Placement Team for assessment and, thereafter, for the development of an appropriate program if warranted.

(b) A child temporarily removed from the classroom for open sores or skin eruptions which cannot be covered should be placed on homebound instruction and readmitted only with medical documentation that the risk no longer exists.

(c) Removal from the classroom under sections (a) and (b) above should not be construed as the only responses to reduce risk of transmission. The school district should be flexible in its response and attempt to use the least restrictive means to accommodate the child's needs.

(d) In any case of temporary removal of the student from the school setting, state regulations and school policy regarding homebound instruction should apply.

8. Each removal of a child with AIDS/ARC from normal school attendance should be reviewed by the school medical advisor in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

9. A child with AIDS/ARC, as with any other immunodeficient child, may need to be removed from the classroom for his/her own protection when cases of measles or chicken pox are occurring in the school population. This decision should be made by the child's physician in consultation with the school nurse and/or the school medical advisor.

10. Routine and standard procedures should be used to clean up after a child has an accident or injury at school. Blood or other body fluids emanating from any child, including ones known to have AIDS/ARC should be treated cautiously. Gloves should be worn when cleaning up blood spills. These "spills" should be disinfected with either bleach or another disinfectant, and persons coming in contact with them should wash their hands afterwards. Blood soaked items should be placed in leakproof bags for washing or further disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in any child. Handwashing after contact with a school child is routinely recommended only if physical contact has been made with the child's blood or body fluids, including saliva.

Note: The task force operated under the jurisdiction of the Connecticut education and health departments.

For more information, contact Elaine Brainerd, School Health Services, Connecticut State Department of Education, P.O. Box 2219, Room 355, Hartford, Conn. 06145, (203)566-3461.

Source: Connecticut State Department of Education

APPENDIX G

School District Of Philadelphia
Policy On AIDS-Infected Students And Employees
November 1985

The board of education is committed to the provision of a healthful environment for its students and employees.

In fulfillment of that commitment, the board has and shall continue to seek guidance from appropriate medical, educational, legal and government authorities. This policy statement is the result of such guidance.

AIDS is an acronym for acquired immune deficiency syndrome. As used in this policy, AIDS includes all infections caused by the human T-lymphotropic virus, Type III (HTLV-III), also called lymphadenopathy-associated virus (LAV) and includes acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and asymptomatic infections of these viruses.

This policy shall apply to all students and employees in all programs conducted by the School District of Philadelphia.

Management of the school district for this disease shall be the responsibility of the director for health services.

Each case shall be considered on an individual basis consistent with the recommendations of the Centers for Disease Control.

A student or employee with AIDS shall be admitted to the classroom or program provided such admission has been approved by a screening committee consisting of the director for health services, who shall serve as chairperson, a physician named by the superintendent and a physician named by the commissioner of health of the City of Philadelphia.

The committee shall consult with the attending physician, the child's parent or guardian and, if necessary, with educational personnel in the proposed placement.

Decisions shall be based both on the student's susceptibility to other diseases and the student's likelihood of presenting risk of infection to others.

The screening committee may make limited waiver of the physician-patient privilege a condition of admission to the extent necessary to protect the patient and others.

Periodically, the screening committee shall review each case to determine current status and make revisions, if necessary, in the original decisions.

An employee with AIDS shall be admitted to his/her place of employment in accordance with provisions of this section.

The identity of students or employees with AIDS shall be confidential except to the limited extent provided [above].

All files that include listing of names and other confidential information of those with AIDS shall be kept under strict security by an official named by the superintendent.

First consideration should be given to returning the student or employee to the regular assignment. Any decision for an alternative placement must be supported by specific data.

Students diagnosed as having AIDS and unable to attend school as determined by medical examination shall be considered for homebound instruction.

A student with AIDS may be excused from school attendance if the parent or guardian seeks such excuse based upon medical or psychological advice of those treating the student.

A student may be excused from school attendance by the board upon satisfactory evidence of urgent reasons which prevent the student from attending school or application to study. Such an excuse must be approved by the Pennsylvania Department of Education prior to the exclusion.

The mandatory high school course of study in health education shall be expanded to include AIDS and such instruction shall be extended, with appropriate adaptations, to the junior high school.

The Division of Health Services shall develop appropriate administrative guidelines to implement this policy. The guidelines of the United States Center for Disease Control shall be the major reference.

The director of health services shall periodically report to the superintendent regarding the effectiveness of this policy and make recommendations for revision in response to developments in medical research and treatment.

For more information, contact the School District of Philadelphia, Health Services, Parkway at 21st St., Administration Bldg., Room 115, Philadelphia, Pa. 19103, (215)299-7481.

Source: School District of Philadelphia

APPENDIX H

Supreme Court Of The State Of New York,
County Of Queens
Decision On AIDS In The New York City Schools
February 1986

Index No. 14940/85

Application of DISTRICT 27 COMMUNITY SCHOOL BOARD, by its President, SAMUEL GRANIRER; DISTRICT 29 COMMUNITY SCHOOL BOARD; SAMUEL GRANIRER, as Parent and Natural Guardian of LOUIS and PAMELA GRANIRER; and SAMUEL GRANIRER, Individually,

Petitioners,

For a Judgment Pursuant to Article 78 of the CPLR

against

THE BOARD OF EDUCATION OF THE CITY OF NEW YORK, NATHAN QUINONES, as Chancellor of the BOARD OF EDUCATION OF THE CITY OF NEW YORK, JAMES F. REGAN, as President of the NEW YORK CITY BOARD OF EDUCATION, The DEPARTMENT OF HEALTH OF THE CITY OF NEW YORK, DAVID J. SENCER, as COMMISSIONER OF HEALTH, and THE CITY OF NEW YORK,

Respondents.

APPEARANCES:

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INTRODUCTION

Some five years ago, a new and terrifying illness was first recognized in the human population—the phenomenon we have come to call Acquired Immune Deficiency Syndrome ("AIDS"). AIDS has since become America's most feared acronym, a catastrophic disease that destroys the very mechanisms by which the body fights off disease. The statistics on its proliferation have become numbing, but they bear repeating here. As of September 30, 1985, physicians and health departments had reported to the Centers for Disease Control ("CDC"), since 1981, 13,611 patients nationwide (13,420 adults and 191 children) who met the surveillance definition for AIDS. Almost one-third of all cases have been reported during the first nine months of 1985. Approximately 7,000 of all reported patients are known to have died (51% of the adults and 63% of the children); 75% of patients diagnosed before 1983 are known dead.[1] New York City has the unenviable distinction of having the highest concentration of reported cases of AIDS in the United States. As of September 6, 1985, the New York City Department of Health had recorded, since 1978, 4,531 AIDS cases, including 2,354 (52%). The total number of cases continues to double every ten to twelve months. Among the New York City-reported cases were 82 children under 13 years of age, who met the CDC surveillance criteria for pediatric AIDS, of which 56 are known to have died, a frightening mortality rate of 68%. Eighty-four percent of the pediatric cases reported to the Department of Health occurred among children who have one or both parents with AIDS or who are members of a known group at increased risk of acquiring AIDS, which includes bisexual men, intravenous drug abusers, former residents of coun-

tries with unidentified risk groups, and hemophiliacs. Seven percent of such cases occurred among children who had received blood or blood products; no risk has been identified in 3% of the pediatric AIDS cases; and, in the remaining 6%, investigations are incomplete or continuing.

AIDS is a clinical diagnosis of a disease complex characterized by a collapse of the body's natural immunity against disease. Because the immune system collapses, victims fall prey to one or more infections or rare cancers, known as opportunistic infections, that do not pose a threat to anyone whose immune system is functioning normally. There is no known cure for AIDS at present.

Although the origin of AIDS still remains a subject of vigorous debate in medical circles,[2] in 1983 and 1984 scientists in France and the United States independently succeeded in implicating a human retrovirus variously labeled human T-cell lymphotropic virus Type III ("HTLV-III") or lymphadenopathy-associated virus ("LAV") as the probable causative agent responsible for AIDS. The AIDS virus is only the third human retroviral agent to be isolated from patients; the two previously discovered retroviruses (HTLV-I and HTLV-II) are believed to cause rare forms of leukemia in humans. Further research has shown that the AIDS virus attacks the T-4 lymphocytes, a subgroup of white blood cells called variously T-4 or T-helper cells, which cells are crucial to the immune defenses because they activate cells (B cells) in our immune system to defend against and destroy foreign agents, material, bacteria and virus, and other cells (T-8 or T-Suppressor cells) to modulate the reaction of the T-4 cells so as to prevent damage to the body's own tissues. When the T-4 cells are removed from this complex system, the entire immunological defensive system is crippled, leaving its victim acutely vulnerable to the opportunistic infections associated with AIDS. Most alarming is recent evidence that the AIDS virus may directly infect cells within the human brain and central nervous system, resulting in severe neurological disorders and brain damage.[3] In short, it is the HTLV-III/LAV virus, and not the syndrome known as AIDS, that is contagious or transmissible, infiltrating and sabotaging the body's center for disease control, fomenting chaos and immunological anarchy.

Currently there is a blood test available that detects the presence

of antibodies that indicate previous exposure to the HTLV-III/LAV virus. A positive test only indicates that a person has been exposed to the virus at some time and infected long enough to develop antibodies to it; it does not reveal whether infection is still present and can be transmitted, whether immunity to further infection has been acquired, or whether AIDS will develop. Because the antibody test is designated for high sensitivity, it also has a small margin of error for false positive and false negative results. Thus, the test is not a diagnostic tool to screen individuals, but is being used primarily to screen donated blood as a precaution to protect the blood supply for transfusion.

With the development of seriologic tests to detect antibody against this virus, it has become possible to determine more accurately a full range of clinical manifestations of HTLV-III/LAV infection.

The case definition of AIDS promulgated by the CDC for national reporting continues to include only the more severe manifestations of HTLV-III/LAV infection. CDC defines a case of AIDS for epidemiologic purposes as a syndrome in which a person has a reliably diagnosed opportunistic infection or malignancy at least moderately indicative of underlying cellular immuno-deficiency, where there is no known cause of the immuno deficiency. Other persons infected with HTLV-III/LAV develop less specific or milder symptoms indicating a suppressed immune system, such as persistent swollen lymph glands, unexplained fever and weight loss. These clinical and immunologic characteristics are referred to as "AIDS-related complex" ("ARC"). Perhaps approximately 10% of the adults who are infected with HTLV-III/LAV, as some studies suggest, will ever progress to ARC. A small percentage of ARC patients go on to develop a life-threatening opportunistic infection classifying them as having AIDS. One study followed 200 ARC patients over three years, of whom 30% converted to AIDS.

The majority of individuals who have been infected with the virus do not develop any symptoms, although many may reveal mild to moderate immune deficiency upon clinical examination. It is conservatively estimated that between 300,000 and 1,000,000 persons in the United States have asymptomatic infection with the virus. In New York City, it is currently estimated that 350,000 to 400,000 adults are asymptomatic carriers (most of them people with one of the classic risk factors for AIDS),

while the number of asymptomatic but infected school-aged children (5-18 years of age) ranges from 200 to 2,000. Although the risk of developing ARC or AIDS by people infected with the virus remains unknown, some laboratory studies suggest that an infected person poses the same if not potentially more significant risk in transmitting the virus to others based upon immunologic evidence that the virus is more easily recovered during the ARC and asymptomatic stages than with AIDS; this is attributed to the fact that the rapid replication of the virus in an AIDS victim will have already infected and thus destroyed a large proportion of the lymphocytes from the seminal body fluids associated with the documented and theoretical modes of transmission.

The incubation period for adults is thought at present to range from a few weeks to as long as seven years; children who are infected *in utero* or via transfusion during the neonatal period usually develop symptoms within five and one-half to 13 months. Most of the pediatric patients in New York City who developed the full-blown syndrome died of their disease, on the average, nine months after the onset of an opportunistic infection.

I

In a joint statement issued on August 30, 1985, by Mayor Edward I. Koch, New York City Schools Chancellor Nathan Quinones, Board of Education President James F. Regan, and Health Commissioner Dr. David J. Sencer, a policy was announced under which all children with AIDS would not be automatically excluded from the New York City public schools, but would be reviewed on a case-by-case basis to determine whether their health and development permitted them to attend school in an unrestricted setting. Thereafter, under the auspices of the New York City Department of Health, a four-member panel was established to review the condition of each school-aged child reported as having AIDS or suspected AIDS and to make recommendations as to the appropriate educational placement for that child. Pursuant to the panel's report, the Commissioner of Health recommended to the Chancellor that one seven-year-old child ("John/Jane Doe"), who several years ago had been diagnosed as having AIDS, but who has remained well and done well in school for the past three years, should continue in

school, and that the child's identity should remain confidential. This recommendation was accepted by the Chancellor and Board of Education and a joint statement announcing the decision was issued on September 7, 1985, two days before the commencement of the school year.

That announcement was the impetus for the application to this court by petitioners, two local community school boards from District 27 and 29, and an individual, Samuel Granirer, who is president of one of the boards and the father of two children attending New York City public schools, for an order to show cause, a temporary restraining order and a permanent injunction prohibiting respondents from admitting the unidentified child with AIDS to any public school within New York City attended by students without AIDS. On September 9, 1985, the court denied petitioner's application for a temporary restraining order, but set the case down for trial on September 12, 1985, on which date an amended petition was filed seeking a judgment, pursuant to Article 78 of the Civil Practice Laws and Rules, requiring the expulsion of John/Jane Doe from school, as well as disclosure of both the child's identity and the school the child is attending.

On September 13, 1985, the court granted a renewed motion to intervene by John/Jane Doe, the child whose school attendance was challenged by petitioners, and on September 18, 1985, the court granted a motion by the President of the New York City School Board's Association to intervene as a petitioner.

During the five-week trial, the court heard testimony from 11 medical experts, including Health Commissioner David Sencer and various physicians who explored the issues concerning AIDS, HTLV-III/LAV and related medical problems. In addition, Commissioner Sencer, Chancellor Quinones, and Dr. Polly Thomas, employed by the Department of Health as a pediatrician epidemiologist, specializing in AIDS and an appointed member of the panel, testified concerning their individual participation and the function and role of their respective agencies in developing and implementing the City's policy regarding students with AIDS.

While the trial was in progress, Commissioner Sencer convened a second panel of seven distinguished physicians—four of whom had previously testified as principal witnesses to review

John/Jane Doe's status. On November 14, 1985, exactly one month after the trial concluded, the second medical panel reported that, after reviewing the medical facts in detail and extensively interviewing the child's treating physician, they unanimously concluded that John/Jane Doe does not meet the CDC surveillance definition of AIDS, but has been infected with the HTLV-III/LAV virus and clinically evidences immune suppression. Thus, this child is no different from the estimated many school children who are infected with HTLV-III/LAV but who do not have AIDS and who are unknown to the health or school authorities.

Notwithstanding that such finding raises the spector that the issues to be determined here may have been rendered moot as it relates to the Doe child, the court will nonetheless entertain those issues, particularly since they are likely to recur, and are of sufficient public importance and interest. (See, e.g., *Matter of Storar v. Storar*, 52 NY2d 363, 369-70.) This is not to suggest that this lower court views itself as having the legal stature or broad powers of review of a Court of Appeals, a tribunal from which guidance is enthusiastically awaited even in matters rendered academic by circumstance; nor does this court mean to suggest that the child in question served no apparent function in bringing important public issues to the forefront. The fact is that the decision not to expel John/Jane Doe from school ignited parental concern and served as the catalyst to opening the courthouse door to a review of the challenged governmental action. In turn, this singular court proceeding became the immediate focus of intense public interest and media attention, involving as it did highly emotional and controversial questions of civil rights, confidentiality, government, and school-aged children touched by one of the most publicized lethal infectious killers known to modern medicine. Such circumstances more or less dictated that this court invoke the rarely utilized power to require a trial of the facts rather than resolve this Article 78 proceeding on the papers alone. Indeed, from the outset, the parties and the court recognized an opportunity to conduct a broad-ranging, aggregative inquiry calculated to advance the public education about AIDS, the disease, and the legal and social issues concerning the exclusion from the regular classroom setting of children diagnosed as having AIDS or ARC or who remain asymptomatic carriers of the virus. In keeping with this well-intentioned purpose, the trial at times necessitated exploring matters not strictly relevant to this one child, examining the

fundamental issues of authority and process under which the respondents reached their determinations concerning school children with AIDS and the rationality behind those decisions as established by the medical and scientific evidence presented in court.

II

This Article 78 proceeding is brought in the nature of a mandamus to determine whether certain decisions made by the New York City Department of Health and Board of Education, through their respective administrative officers, violated a duty imposed by law, or were arbitrary and capricious or an abuse of discretion. The petitioners challenge (1) the threshold decision not to automatically exclude from school all children who have AIDS, but rather to review the appropriate educational placement for such children on a case-by-case basis; (2) the composition and procedures of the original four-member panel; (3) the adequacy and implementation of the special precautions taken within the schools to safeguard against the risks of transmission of the AIDS virus to normal children or other immunosuppressed children; and (4) the decision not to disclose the identity of the AIDS child, even on a very limited basis within the school. Based upon certain questioning at trial, petitioners have raised in their post-trial brief ancillary issues as to whether AIDS is an educationally handicapping condition requiring automatic referral of AIDS students to a Committee on the Handicapped; whether public notice and/or hearings were legally mandated prior to establishing the citywide policy concerning AIDS students in the classroom setting; and whether the Decentralization Law "implicitly" requires consultation by the Central Board of Education with the local community school boards in establishing such policy.

Before determining the efficacy of the policy established by the health and educational departments of the City, the court is obliged to chronicle the events leading up to the within-challenged determinations.

III

In the summer of 1981, prior to the inception of Dr. Sencer's ad-

ministration of the Department of Health, Dr. Polly Thomas, a Board-Certified pediatrician performing epidemiological research on AIDS with the CDC and assigned to New York City, established the AIDS Epidemiologic Surveillance Unit. The function of the surveillance program was to determine the number of AIDS cases occurring within the City limits, in order to assess the impact of the disease, transmission patterns, and groups at risk. Operating under a strictly voluntary reporting system, the Surveillance Unit was successful in first identifying some of the earlier high-risk groups associated with the transmission of AIDS, namely, male homosexuals, intravenous (IV) drug abusers and hemophiliacs and other blood transfusion recipients. Dr. Thomas and fellow Health Department personnel also conducted research into the spread of AIDS.

These and other efforts by the Health Department to learn more about AIDS continued after Dr. Sencer became Commissioner in January 1982, and were enhanced by his instituting monthly meetings on AIDS at the Department, where researchers, clinicians, and other interested persons could exchange information.

The first cases of children with AIDS were reported in the fall of 1982. The majority of pediatric AIDS patients are infants with a parent with AIDS or at increased risk for AIDS. The young age of these children suggests that they were infected *in utero*, at birth, or shortly after birth. By the end of 1982, sporadic pediatric cases were reported from Manhattan, after the first five infants with an AIDS-like disease were identified in the Bronx earlier in the year.[4] In 1983, the Health Department responded to inquiries from science teachers, recommending hepatitis B type blood precautions (e.g., wearing of gloves) for laboratory students. This approach, considered overly cautious since hepatitis B was suspected of being more contagious and readily transmissible than AIDS, was similarly adopted that year in promulgating guidelines and precautions for the care of children with AIDS or a related illness in foster homes.

In June 1983, the Public Health Council approved an emergency amendment to the State Sanitary Code to provide for mandatory reporting of AIDS cases, under strict confidentiality protections, to the New York State Department of Health (10 NYCRR part 24, filed June 21, 1983, eff Oct 6, 1983). In the fall, the New York City Health Code was amended to extend to AIDS case reports and records the confidentiality already afforded to

documents in cases of narcotics abuse and venereal diseases. (NYC Health Code, Section 11.07, subds [a] and [b].) After confidentiality safeguards were in place, the local Health Department was later approved to receive direct reports of all cases or suspected cases of AIDS for transmittal to the State Health Commissioner.

With the detection and isolation of the HTLV-III/LAV virus and the development of a seriologic test for HTLV-III/LAV antibodies, 1984-85 offered greater opportunities to determine more accurately which persons had been infected with the AIDS virus and understand better the modes of transmission of the presumed causative agent of AIDS or ARC, especially as it related to family and health-care settings. In November 1984, Dr. Thomas attended a Florida conference on pediatric AIDS, co-sponsored by the U.S. Department of Health and Human Services, the National Institutes of Health ("NIH"), the Centers for Disease Control ("CDC") and the University of Miami. The consensus among the pediatricians was that children with AIDS could attend school; however, there was divided opinion over the necessity for special precautions, some holding to the view that none were needed, in the absence of any evidence for spread, while others who were not reassured by the then-available epidemiological and clinical evidence felt that hepatitis B type blood precautions should be followed in the schools. Shortly after her return, Dr. Thomas reported on the conference to Dr. Stephen Schultz, the Deputy Commissioner for Epidemiology Services, and suggested that the Department determine its position on the necessity for any hepatitis B/AIDS precautions in New York City's public schools. Although at the time (December, 1984) she knew of only two school-age children with AIDS, both of whom had been placed on home instruction by reason of their handicapping conditions, Dr. Thomas suspected that the number of school children with AIDS would increase and, therefore, alerted her superior that "precedents set now may be difficult to break." The number of pediatric AIDS cases was indeed growing, as revealed in the minutes of the Department's AIDS meeting for March 1985, reporting 56 total cases of children with AIDS as of March 19, 1985, three more since the previous monthly report. In April 1985, Dr. Thomas attended an international conference in Atlanta, Georgia, co-sponsored by the U.S. Public Health Service and the World Health Organization. At this conference, a larger number of studies on the question of transmission was presented for the

first time, including case-control studies conducted to define risk factors for AIDS and HTLV-III/LAV infections in the family setting. In sum, the findings suggested no evidence for casual transmission of the virus within households.

On April 12, 1985, the Deputy Chancellor of the Board of Education, Charles I. Schonhaut, directed a letter to Commissioner Sencer requesting written guidelines from the Health Department on the admission and attendance of children with AIDS/ARC in the public school system. The Commissioner responded in early May, advising that there be no change in the management of the two children on home instruction for the balance of the school year. He further stated his intention to convene a joint effort of the Health Department and Board of Education to draw up guidelines for the 1985-86 school year, and requested that the Chancellor appoint someone to represent the Board. The Deputy Chancellor responded on May 23, 1985, designating Dermott Kehoe, his Assistant for Special Education, to serve as a Board representative. The joint meetings commenced in June 1985, the same month in which Dr. Thomas attended, by invitation, a meeting at the CDC to consider questions relating to the handling of children with AIDS in schools, day care, and foster homes. The unanimous consensus among the medical experts attending the Atlanta meeting was that children with AIDS or infected with HTLV-III/LAV virus could attend school, although there was disagreement about whether any special precautions were necessary. On the basis of the then-available medical knowledge, including the epidemiologic studies suggesting that HTLV-III/LAV transmission is not associated with hospital personnel, household contacts, foster parents, and others who are or have been in close contact with persons with AIDS or related illnesses, the Health Department produced a first draft of the guidelines in early July, establishing a policy of fully integrating children with AIDS or related conditions into the public schools. It further provided for management policies on children who have immunosuppression due to AIDS, cancer treatments, or other causes, specifically with reference to exemption from certain vaccinations and measures to be taken in response to reported outbreaks of certain airborne viruses (such as chicken pox and measles), and also set forth recommended precautions in managing bleeding injuries and cleaning surfaces soiled with blood. During the summer, further drafts were exchanged, effectuating no substantive changes from the original. Despite the fact that guidelines were being

formulated and were in their fourth and fifth drafts by the third week of August, Chancellor Quinones reported the lack of any guidelines to Deputy Mayor Stanley Brezenoff, who then ascertained from Commissioner Sencer that a joint effort had been under way since June 1985. The final draft was completed by August 26, 1985, but not offered for public dissemination because Dr. Sencer thought it inappropriate and ill-advised to commit New York City to a particular policy before reviewing the CDC guidelines which, he understood, were imminent.

About this same time, in late August, the local community school boards from Districts 27 and 29 in Queens County, totally unaware that the Health Department and Board of Education were engaged for some three months in a joint effort to formulate guidelines for the school system or children with AIDS and that the issue had even been under consideration since April 1985, respectively adopted resolutions to exclude such children from any school under their jurisdiction.

On August 29, 1985, Commissioner Sencer received a copy of the CDC's guidelines,[3] one day before its official release. Those recommendations were furnished to assist state and local health and education departments in developing guidelines for their particular situations and locations, and were to apply to all children known to be infected with HTLV-III/LAV virus. Their basic theme is that infected school-aged children should be allowed to attend school in an unrestricted setting unless they are neurologically handicapped and lack control of their body secretions or display behavior such as biting. According to the document, the theoretical potential for transmission among HTLV-III/LAV-infected neurologically handicapped children, as well as infected preschool-aged children, is premised not on any current evidence that such children posed any risk of transmission of the virus, but rather on experience with "other communicable diseases." The CDC emphasized that "any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person." It further suggested that a "team approach" be considered in evaluating the behavior, neurologic development, and physical condition of each HTLV-III/LAV-infected child for purposes of determining the appropriate education setting.

Dr. Sencer viewed the CDC's concern regarding the theoretical

risk of HTLV-III/LAV transmission through the "bodily fluids" of infected preschool-aged and neurologically impaired children as irreconcilable with the current immunologic and epidemiologic evidence concerning AIDS, and also disagreed that a committee to review infected children was necessary. Nevertheless, taking what he terms "the cautious approach," the Commissioner augmented the nonexclusion policy already expressed in the drafts of the New York City guidelines by alone deciding that children with AIDS who are physically, mentally and developmentally capable of attending school in an unrestricted setting should not automatically be excluded and their educational placement should be reviewed on a case-by-case basis by a multi-disciplinary panel jointly appointed by the Commissioner and the Chancellor of the Board of Education. Chancellor Quinones concurred in that decision.

Dr. Sencer then "reluctantly" instructed his AIDS Epidemiologic Surveillance Unit to search the data for school-aged children for presentment to the review committee. He also discussed with general counsel procedures to preserve the confidentiality rights of the physician, patient and parent, and spoke to the respective physicians. To assure confidentiality of medical information, it was decided that the committee would function from within the Department of Health.

On August 30, 1985, with the CDC guidelines officially released, the Commissioner, the Chancellor, the President of the Board of Education and the Mayor issued a joint statement announcing that a specifically constituted committee, consisting of "experts on AIDS and pediatrics . . ., an experienced educator from the Board of Education and a parent representative," was to review the health and development of each of the then-known school-age children with AIDS, all under seven years old, and recommend the appropriate educational setting for that child. Presumably in reaction to the news release, a mailgram was sent that date by the District 27 Community School Board, inviting various Health Department personnel, including the Commissioner, Dr. Thomas and Dr. Samples (Director of School Health Program) to a meeting scheduled for September 5, 1985.

Two days after the announced intention to convene a panel, Mayor Koch publicly voiced his opinion that "caution" and "good common sense" suggested that younger children suffering from AIDS should not attend New York City public schools,

further predicting that the panel charged with assessing such case would agree with him.[4]

On September 3, 1985, Dr. Thomas received word from the Commissioner of her appointment to the panel as a pediatrician and expert on pediatric AIDS. Together with Dr. Sencer, she prepared a form of questionnaire to be used by the panel in questioning the individual child's physician. The other three members of the panel were Suzanne Michaels, a licensed social worker employed by the Health Department as liaison to the Board of Education on school health matters; Rosalyn Oratz, an executive employee of the Board of Education, formerly an elementary school teacher and principal, whose areas of responsibility include school health; and Agnes Green, a parent, the President of the United Parents' Association, Inc., and a member of Community School Board 17.

On September 4, 1985, the New York State Department of Health followed the lead of the federal health agency by releasing guidelines mirroring those of the CDC. The State Education Department thereupon distributed the state and federal guidelines, together with its policy recommendations, which principally relied on both documents, to all District Superintendents, Superintendents and Principals of public and non-public schools. In the early afternoon of that same day, Commissioner Sencer addressed the Central Board of Education of New York City in Executive Session. The minutes of that meeting indicate that the Board concurred with Dr. Sencer's recommendations with regard to the admission of children with AIDS to school; the CDC recommendation for the establishment of a review committee to screen each case prior to admission; the composition of such a committee; the fact that seven school-age children would be reviewed initially and whose anonymity would be preserved; and the committee's province to decide whether the child's condition should be revealed to anyone in the school.

The panel began its deliberations on September 5, 1985. Dr. Sencer attended the first hour of the meeting, addressing questions on AIDS, also furnishing certain literature and reviewing the questionnaire and general procedures of the panel. The procedures followed by the panel are best summarized in its report to the Commissioner:

"The panel reviewed the literature on AIDS, the recommendations of the Centers for Disease Control, and discussed AIDS with medical personnel. Transmission of AIDS and of the infections that pediatric AIDS patients are susceptible to were also discussed.

"The panel then reviewed the physical as well as behavioral aspects of the children with AIDS that have been reported to the Department of Health. To do this the panel used a written questionnaire which enabled a standardized and comprehensive review of each case. The questionnaire included the medical history, including immunization and records of hospitalization, current physical condition, psycho-social and developmental evaluations, social history of the child and his/her previous school history, questions on the child's emotional state, parental understanding and ability to comply with medical treatment and utilize social services were also examined.

"Physicians treating the children were interviewed in an anonymous manner. After the formal questionnaire was completed, the panel members asked the physicians and social workers for additional clarification and information if needed.

"After each case the panel discussed the specific child's case in all its aspects and reached agreement on the recommendations contained in the next section."

The panel considered seven children in all. Three of these children no longer reside in New York City. One child was hospitalized due to illness and receiving instruction in the hospital. Another was healthy but was living in a hospital and receiving instruction there, pending resolution of a family problem. The third child was physically and emotionally capable of attending school, but because the confidentiality concerning that child's illness had been breached, the panel recommended that the family consider alternative educational opportunities.

As for the fourth child, the panel reported as follows:

"The fourth child is well, has successfully completed the first grade after attending a nursery school and public kindergarten and should attend school. This child who was born with the HTLV-III infection was ill three years ago with one of the conditions that is associated with AIDS. Medical examinations at that

time revealed that the child had a depressed immune system and the diagnosis of AIDS was made. Subsequently the child recovered from the medical condition and has remained well. The child has received the childhood immunizations that are necessary for school admission. In addition the child has had chickenpox, one of the childhood diseases for which there is no immunization and had an uneventful recovery. This is further indication that the student's physical stamina is excellent. The physician emphasized that the social development of the child is normal both in school and at home where there are other children."

To avoid during trial the potential for any breach of confidentiality concerning information reported by this child's physician to the panel, counsel stipulated that Dr. Thomas gave in effect the following testimony:

"First: On September 3, 1985, the four-person panel spoke by telephone to Dr. X, the attending physician of John/Jane Doe.

"2. Dr. X was known to Dr. Thomas to be a reputable physician with experience in the field of AIDS.

"3. Dr. X, stated among other things, that John/Jane Doe was a second grade student, was not incontinent and had no history of nose bleeds; that the child had no motor abnormalities, did not require any medicine or treatment during school hours and had no special diet and no condition that would cause its activity in school to be limited, and had no history of biting.

"Dr. X also informed the panel that the child's intellectual and emotional development was normal, and its social development was above normal.

"Dr. X informed the panel that the child had in 1983 been diagnosed as an AIDS patient or an AIDS case.

"Dr. X also told the panel that it was not necessary for John/Jane Doe to be removed from school in the event of an outbreak of chickenpox or measles because the child had had chickenpox, had been immunized against measles and his/her immunological system was not so suppressed that Dr. X would, in any event, be concerned about exposure to those illnesses."

On the same day that the panel began its deliberations, just four days prior to the opening of school, the Office of the Vice-President of the Board of Education attempted to convene a meeting of the Consultative Council, which is made up of representatives of the 32 Community School Boards, to discuss the issue of AIDS. The Secretary of the School Boards Association responded that the subject of AIDS could await discussion until the next regularly scheduled meeting for September 12, 1985. However, the Chancellor himself got the opportunity on September 5, 1985, to discuss the AIDS topic with Community School Board Superintendents, although District 27 was not represented at that meeting.

On September 6, 1985, the panel discussed its findings and recommendations with the Health Commissioner. The Commissioner agreed with the panel, based on the facts presented, that the fourth child should continue in school and that its identity should remain confidential. That decision was announced in a joint statement of the President of the Board of Education, the Chancellor and the Commissioner on September 7, 1985. The statement further noted: "Obviously this decision was not made lightly. We are concerned about the health of all children in the system, those identified as having the AIDS syndrome and the children who are not ill. We are convinced that the continuation of the presence of this child in public school poses no threat to the other children, or to this child."

On September 9, 1985, the school year commenced under a cloud of confusion, distrust and protest, with some parents actually opting to keep their children at home until the second-grader known to have AIDS, wherever he or she might be located, was removed from school. In the meantime, Districts 27 and 29 Community School Boards were commencing this lawsuit, also seeking injunctive relief excluding this child from school.

On September 10, 1985, Joseph Saccente, Chief of Operations at the Board of Education, and Dr. Sencer met with Community School District 29 on the subject of the New York City policy regarding the attendance of children with AIDS in the school system. On that same day, the Chancellor and the Commissioner met with the Community School District 27 petitioners and their attorney at the Chancellor's office.

The trial began as scheduled on September 12, 1985.

IV

As with many other diseases before it, much of the understanding of the communicability of AIDS has come from the study of its epidemiology. At the trial, a number of distinguished physicians testified with respect to the distribution of the disease and the patterns of spread of the HTLV-III/LAV virus, relying upon the available epidemiologic information that has evolved since the classification of the disease as well as their professional experience in providing care to AIDS/ARC adult and pediatric patients and studying the virus under controlled laboratory conditions. Testifying for the petitioners were Drs. Arye Rubenstein, Pediatrician and Immunologist, Professor of Pediatrics, Albert Einstein Medical College; Jose Giron, Chief of Infectious Diseases, Flushing Hospital and Medical Center; and Lionel Resnick, Virologist, National Institutes of Health. Testifying for the respondents were Drs. Donald Armstrong, Director of Infectious Diseases, Memorial Sloan-Kettering Medical Center; Louis Z. Cooper, Chief of Pediatrics, St. Luke's Roosevelt Hospital Center; and Margaret Hilgartner, Pediatric Hemotologist and Oncologist, Director of Hemophiliac Clinic, New York Hospital, Cornell Medical Center. Also offering medical testimony on behalf of the respondents were Commissioner Sencer and Dr. Pauline Thomas, themselves holding impressive credentials in, respectively, the epidemiology of AIDS and public health service.

Considering that much of the expert testimony over the five-week trial was fairly uniform on the risk factors and modes of transmission associated with the AIDS virus, the court has chosen to compilate only the most salient facts necessary to a comprehensive understanding of that subject.

Most reported AIDS cases may be separated into groups based on one or more well-defined risk factors: homosexual and bisexual men with multiple sexual partners; intravenous drug abusers with no history of male homosexual activity who share needles and other drug paraphernalia; recipients of infected blood and blood products (e.g., hemophiliacs and persons who had blood transfusions); infants born to infected mothers; and heterosexual partners of persons at risk for AIDS.[1] Among the

4,531 reported cases of AIDS in New York City that have been fully investigated, 1% do not fall into one of the identified risk groups for AIDS. Those familiar with the epidemiologic considerations explain the 1% figure by the fact that these non-characteristic victims either deny any AIDS risk behavior (homosexuality, IV drug use, visits to prostitutes), or are unaware that they themselves have been the sexual partner of risk group members. Although the total number of cases in each patient group has increased substantially, the relative proportion of cases within each group has remained remarkably stable over time.

AIDS has become established primarily as a sexually transmitted disease that can also be communicated through contaminated blood or blood products. HTLV-III/LAV has been isolated from bodily fluids such as semen, blood, saliva and tears. The AIDS virus has been found in highest concentrations in blood and semen, and in lower concentrations in saliva and tears. Despite positive cultures from a variety of body fluids of infected persons, there is no concrete epidemiological evidence to date that the virus has been transmitted through contact with the saliva or tears of infected persons, thus leading some physicians to conclude that there probably needs to be a substantial quantity of virus particles to transmit the virus. Attempts to isolate the virus from urine, vomit, stool or cervical and vaginal secretions are in progress, although some doctors expressed the opinion that vomit is not a viable medium for transmitting the virus since the virus would be destroyed by the acid pH of the stomach and its contents.

HTLV-III/LAV, as with the other human retroviral agents, is a relatively fragile virus and is of a lower order of infectivity than, for example, hepatitis B, which is much more stable. The virus is inactivated by disinfectants, such as ordinary household bleach (diluted 1 part bleach to 9 parts water) and 70% alcohol, or by moderate heat.

Reinforced by the total absence of documented cases of HTLV-III/LAV having been transmitted in any way other than by sexual intercourse, by injection of contaminated blood or blood products, including needle sharing, or by an infected mother to her child before or during birth,[8] the experts unanimously agree that the virus is not transmitted by casual interpersonal contact or airborne spread, such as breathing, sneezing, coughing, shak-

ing hands or hugging. After almost five years of experience, the surveillance data collected by local and state departments of health and forwarded to the CDC, as well as epidemiologic studies of families that include AIDS patients and of health-care workers who have been exposed to AIDS patients, speak strongly against transmission of AIDS through casual (non-sexual) contact.

Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the thousands of AIDS patients reported to the CDC have been reported to have AIDS. Over 500 family or household members have been investigated who lived together with persons who were infected with HTLV-III/LAV. Approximately half of those studied were children. Those family members were more than likely exposed to the saliva of infected patients and, to some extent a manifestation of the impoverished and unhygienic environment, had occasion to share beds, food, toothbrushes, baby bottles, towels and eating and drinking utensils with them, often without knowledge for some time that an infected family member was in their midst. The seriologic testing revealed no finding of transmission of the virus by means other than sexual contact, perinatally or blood transfusions. Significantly, in one study of families of children with transfusion-acquired HTLV-III/LAV infection, none of the 50 family household members under 5 years of age, 9 contacts of 6-18 years of age and 31 adults, including 15 mothers [contracted AIDS].[9]

There also have been no confirmed occupation-related cases of AIDS in health-care workers in the United States. Some 1,758 health-care workers who have cared for AIDS patients have participated in studies to determine the potential for occupational transmission of HTLV-III/LAV through parenteral and mucosal routes; many of these workers have sustained accidental needle-stick injuries. Of the 26 who were found to be positive for HTLV-III/LAV, all but three of these persons belonged to a recognized high-risk group. For one of these three health-care workers, epidemiologic information was not available. The other two both experienced needle-stick injuries but denied any AIDS risk behaviors. CDC has noted, however, that in neither of those two cases was a pre-exposure blood sample taken to verify that the infection had not occurred prior to their needle-

stick injuries. In addition, the case involving the female health-care worker from New York City was not fully investigated, according to Dr. Rand Stoneburner, Director of the Health Department's AIDS Epidemiologic Surveillance Unit, who at the behest of the CDC in late July 1985 attempted without success to conduct a further interview of the patient regarding her sexual partner; the second case involving a male laboratory worker revealed no evidence that he had been exposed to HTLV-III/LAV-infected blood. Finally, the reported case from England of a nurse contracting AIDS involved not a mere needle-stick injury, but rather a puncture which involved an "injection" of blood from an AIDS patient into her hand.

Although the present epidemiological and virological information does not support casual contagion through the day-to-day activities or contact in the home, school, day-care or foster-care setting, the presence of HTLV-III/LAV in saliva has nevertheless raised parent concern about the possible transmission of the virus through biting.

In addressing the issue raised by petitioners as to the risk of HTLV-III/LAV transmission through a child with AIDS biting another child or teacher, the opinions expressed by the medical experts on all sides of the case narrowly ranged from the seemingly conservative views of Drs. Giron and Rubenstein ("probably low"; "certainly possible"; "cannot give complete assurances") to the more confident judgments of respondents' witnesses ("no danger"; "beyond remote possibility"; "highly, highly improbable"; "highly unlikely"; "not a risk of transmission"). The near unanimity of opinion that biting is an unlikely route of HTLV-III/LAV transmission in the classroom setting is premised upon the epidemiologic data indicating no evidence that saliva has ever been a means of transmission, even among household members exposed to the saliva of infected persons; the "extremely low" concentration of the virus in saliva as suggested by the infrequency in culturing the virus from the saliva of persons with AIDS; the minimum capacity of younger children to penetrate the skin to the point where enough virus particles could enter the system of the bitten child; and the relative ease in destroying the virus through the same precautions as are taken in the mangementof any human bite, namely, careful washing of the wound with soap and water followed by alcohol.

Since the transmission of the virus appears to occur by direct blood-to-blood contact, there was considerable testimony at trial as to whether HTLV-III can be transmitted in a classroom setting through blood from an injured child with AIDS getting into an open cut of another child or teacher.

It is undisputed that the mere presence of HTLV-III/LAV in blood does not mean that it can be easily transmitted by external blood-to-skin contact. Most of the physicians' testimony was addressed to the subject of the so-called "theoretical risk" of transmitting AIDS through exposure of open skin lesions or mucous membranes to blood of an infected child during a fight, as a result of a nosebleed, or even from the childhood practice of becoming "blood brothers/sisters." Some doctors expressed skepticism that a theoretical potential for transmission is likely inasmuch as the epidemiologic studies of health-care workers demonstrate the difficulty in transmitting HTLV-III/LAV even where there is exposure to infected blood from needle-stick injuries; indeed, these studies support the conclusion reached by several doctors that it would probably take a large amount of blood with a large quantity of virus particles entering into the bloodstream to transmit the disease. Several doctors dismissed the risk of transmission posed by a mixing of blood as the result of a school fight as "generally improbable"; "wild speculation"; "extremely, highly improbable"; and "practically non-existent". Dr. Hilgartner, a hematologist, further explained that if blood from one person were to drip on another person who had a fresh cut in the skin, the degree of co-mingling of blood would be extremely small because the healing process in which a clot forms, with fibroblast sealing the cut, creates a natural barrier to prevent any virus from entering.

Whatever minimal theoretical risk exists, the experts substantially agree that all blood spills and bleeding wounds should be treated with care regardless of whether children with AIDS/ARC are attending because there are other blood-borne illnesses that may be transmitted, some of which (such as hepatitis B) are considered more contagious than HTLV-III/LAV, and there may be asymptomatic carriers of HTLV-III/LAV present. Thus, the routine precautions to deal with the AIDS virus that have been recommended by the experts, as well as the CDC, closely follow those used with the hepatitis B virus infection: good handwashing with soap and water, followed by

application of alcohol; prompt cleaning of soiled surfaces with disinfectants, such as household bleach diluted 1 part bleach to 9 parts water; preferably with gloved hands; avoiding exposure to open skin lesions or mucuous membranes by covering bleeding or oozing cuts or abrasions whenever possible by a gauze dressing or bandage.

V

To the extent that petitioners can establish that the Commissioner of Health and Chancellor of the Board of Education have not satisfied mandatory directives of existing statutes and regulations, mandamus will lie to compel performance of their legal duties (CPLR 7803[1]; *Klostermann v. Cuomo*, 61 NY2d 525, 539; *United Methodist Retirement Devel. Corp. v. Axelrod*, 110 AD2d 292, 294.) The court is thus obliged to determine whether these administrative officers were under any legal duty to automatically exclude children with AIDS from the public schools, or to promulgate any formal rules or regulations after notifying the public and holding hearings in connection with the automatic exclusion policy challenged herein.

The petitioners rely on various provisions of the New York City Public Health Code to support their contention that the Commissioner of Health and Chancellor of the Board of Education are required by law to exclude any AIDS/ARC/HTLV-III child from the public school system. Section 11.67 of the Health Code prohibits the intentional or negligent spread of disease by persons who are "cases or carriers of *communicable disease*." (Emphasis added.) Section 45.17(b) of the Health Code states, in relevant part: "The person in charge of the ... school or children's institution shall isolate cases and carriers of *communicable disease* and provide facilities for their isolation pursuant to section 11.57." (Emphasis added.) Similarly, section 49.15(d) mandates the exclusion of any child from the elementary and junior high schools as well as public and private high schools "who is a case, contact or carrier of *communicable disease* when required to be isolated or excluded by Article 11 of this Code." (Emphasis added.) Although all the foregoing regulations relate to the control of "communicable disease," in fact, the term "communicable disease" is not defined at all in the Health Code. Instead, such disease for which special precautions must be taken, such as isolation and exclusion, is treated separately under Article 11. For instance, specific restrictions

apply to cases and contacts of chicken pox (section 11.13), diphtheria (section 11.19), infectious hepatitus (section 11.25), measles (section 11.29) and small pox (section 11.43). (See NYC Health Code, sections 11.11 through 11.55). Yet, Article 11 does not treat AIDS as a communicable disease or contain any specific precautions or restrictions relating to AIDS cases, carriers or contacts. At best, the regulations of the City treat AIDS as reportable, but not communicable. While AIDS does not appear on the general list of diseases and conditions reportable to the Department as set forth in section 11.03 of the Health Code, cases or suspected cases of AIDS are reportable under a special section (NYC Health Code, section 11.07, as amended, September 26, 1983) that accords such case reports and records confidentiality. The fact that AIDS is "reportable" does not mean, however, that it has been classified as "communicable." For example, as respondents correctly point out, falls from windows and instances of food poisoning are reportable (section 11.03), but certainly are not communicable. Thus, since AIDS is nowhere defined or classified as a communicable disease, the health regulations of the City of New York relied upon by petitioners are all inapplicable.

At the state level, the power rests with the Public Health Council to "designate [in the Sanitary Code] the communicable diseases which are dangerous to the public health" (Public Health Law, section 225(5)(h)).[10] The statute defines the word "communicable" as an "infectious, contagious or communicable disease" (Public Health Law, section 2(1)). While the Public Health Council has designated some 42 diseases as "infectious, contagious or communicable" (10 NYCRR 2.1[a]), it has not included AIDS among the list of such diseases. Thus, despite the State Public Health Council having addressed the AIDS issue by emergency measures making cases or suspected cases of AIDS reportable to the State Department of Health on a strictly confidential basis (10 NYCRR 24.2, filed June 21, 1983, effective October 6, 1983), and more recently, authorizing the closing of any bars, clubs and bathhouses "in which high risk sexual activity takes place" (10 NYCRR 24-2, filed October 25, 1985, effective December 23, 1985), it has apparently declined to exercise its statutory power to amend the sanitary regulations (Public Health Law, sections 220, 225), to include AIDS on the list of communicable diseases.

Here too, the fact that AIDS is reportable does not classify it as a

"communicable" or "infectious" or "contagious" disease. In any event, to the extent the amended petition relies on section 906 of the State Education Law, which requires exclusion of pupils with an "infectious or contagious disease reportable under the Public Health Law," such reliance is misplaced since that statute is inapplicable to the City of New York (see Education Law, section 901).

Thus, petitioners have failed to demonstrate that respondents were required by law to exclude AIDS children from the classroom. In fact, the State Public Health Council and State Education Department addressed this very issue and concluded:

"For most infected school-aged children, the benefits of an unrestricted setting outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care in an unrestricted setting."

Petitioners take the position that any policy or recommendation with respect to the non-exclusion of children with AIDS emanating from either respondent Sencer or respondent Quinones would either have to have been preceded by public hearings or have been taken at an open meeting. The contention is premised upon several statutory provisions.

Section 1105 of the New York City Charter provides *inter alia*:

"a. Each head of any agency *may*, except as otherwise provided by law, make rules and regulations for the conduct of his office or agency.

b. No rule or regulation of an officer of the city or of a city agency, including but not limited to those with respect to the fixing of any charges of penalties, not an amendment or addition thereto, shall be adopted or repealed pursuant to any provision of this Charter, unless, prior thereto, there shall be afforded by such officer or agency an opportunity for interested persons to comment in writing thereon published at least twice in the City Record ..." (Emphasis added.)

The statute is permissive. The Commissioner of Health has broad power and discretion to protect the public health and to

prevent the spread of disease. (New York City Charter, section 556; NYC Health Code, section 3.01[c].) Petitioner has failed, however, to demonstrate that the exercise of that authority must take the form of a rule or regulation. Moreover, since the non-exclusion policy perpetuated the status quo requiring no affirmative direction, it would stand to reason that no rule or regulation would have been promulgated.

Petitioners next contend that the Board of Education's acceptance of the Department of Health's policy was improper and that an independent basis for the policy following public hearings must be exhibited by the Board of Education. In *New York State Assn. for Retarded Children, Inc. v. Carey* (466 F Supp 479 [E.D.N.Y.], affd 612 F2d 644[2d Cir, 1979]), the District Court did hold that the Health Department's guidelines relied on by the Board of Education were not entitled to the weight accorded to regulations, stating at page 501:

"...[W]here, as here, the Health Department recommendations were more akin to a general statement of policy than a mandatory prescription, the Board's decision to follow the recommendation must be deemed voluntary. Consequently, the Board must be prepared to defend its own action on the merits. *Pacific Gas and Electric Co. v. Federal Power Commission*, 164 U.S. App. D.C. 371, 376-377, 506 F.2d 33, 38-39 (1974); *Engel v. Vitale*, 18 Misc.2d 659, 668, 191 N.Y.S.2d 453, *aff'd* 10 N.Y.2d 174, 218 N.Y.S.2d 659, 176 N.E.2d 579 *rev'd on other grounds*, 370 U.S. 421, 82 S.Ct. 1261, 8 L.Ed.2d 601 (1962)."

Based on this holding, petitioners claim that respondent Quinones was required to independently conduct public hearings. Subdivision 4 of section 2590-g of the Education Law provides:

"In addition the city board shall have power and duty to: ...

"4. Hold public hearings on any matter relating to the educational welfare of the city school district or other matters within the scope of its responsibilities *whenever required to do so by law, or whenever in its judgment the public interest will be served.*" (Emphasis added.)

Petitioners have failed to show any statutory mandate requiring

a public hearing. The contention is also inconsistent with the statute's permissive language.

It should be noted further that petitioner would require respondent Quinones, independent of the medical information obtained by the Department of Health, to seek out its own experts and obtain dissenting medical information. This court is not convinced that respondent was not entitled to rely on the expert medical information acquired by the Department of Health, particularly where the Board of Education was in some measure involved in the acquisition of such information. In this case, unlike *New York State Assn. for Retarded Children, Inc. v. Carey* (*supra*), a committee jointly peopled by Department of Health and Board of Education staff was meeting since June 1985 to formulate guidelines on the admission and attendance of children with AIDS/ARC in the public school system. Absent proof to the contrary, it can hardly be disputed that the high-level officials representing the interests of the Board of Education, as participants on the joint task force, were informed about the available epidemiologic evidence as well as the consensus reached at the CDC meeting held that same month supporting the full integration of children with AIDS or related conditions into the public schools. In fact, as the record established, the draft guidelines that emanated from this joint effort reflected, broadly speaking, the policy of non-exclusion. Thus, while it is inexcusable that Chancellor Quinones neither communicated on this issue with Dr. Sencer or even his own staff, as demonstrated, parenthetically, by his resorting to the Deputy Mayor in late August, the fact is the Board staked its position on the "apparent non-existent risk of transmission of HTLV-III/LAV" in an unrestricted classroom setting.

Petitioners' finally argue that public observation was mandated by the "open meeting law" (Public Officers Law, section 100, *et seq*), and that prior consultation with the affected local school board is implied from the spirit of the Decentralization Law (petitioners concede that consultation is not specifically mandated).

Section 103(a) of the Public Officers Law provides:

"Every meeting of a public body shall be open to the general public, except that an executive session of such body may be

called and business transacted thereat in accordance with section ninety-five [renumbered section 105] of this article."

A public body is any entity for which a quorum of two or more persons are required for the performance of a governmental function. (Public Officers Law, section 102[2].) The policy determination here was made by respondent Sencer and not by a public body as that term is defined.

Finally, petitioners contend that the Executive Session of the Board of Education should have been conducted in public. While the court would agree, since the only action taken there was a blanket endorsement of the Sencer policy, no independent policy having been made, it will not require that an open meeting be rescheduled. Future policy, however, should be developed in conformity with the statute. While this wide-ranging trial has ameliorated the affect of any statutory violation, the Chancellor and the Central Board should be admonished for abdicating their public responsibility to the court.

With respect to the Decentralization Law, some comment must be made, however, with regard to the relationship between the Chancellor, the New York City Board of Education and the community school boards. Much reliance is placed on the letter rather than the spirit of the law. Clearly, the City Board and the Chancellor may establish minimum city-wide policy which must be followed by the community boards. (Education Law, section 2590-g; see, e.g., *Matter of New York City Boards Assn., Inc. v. Bd. of Educ.*, 39 NY2d 111, 119; *Kryger v. Bd. of Educ.*, 37 AD2d 622, 623.) Furthermore, the powers conferred upon community boards are limited to those "not inconsistent with ... the policies established by the city board." (Education Law, section 2590-e.) Case law provides little guidance as to how far the City Board may go in defining city-wide policy. A broad interpretation of this case law could result in the effective emasculation of community boards. Such result would unquestionably be contrary to legislative policy. Without seeking to resolve the tension between the establishment of city-wide policy and local control, the court notes that community school board legislation established a system under which all of the elements are to work in conjunction in governing the education system. In establishing policy in this case, the policy makers had a system in place which allowed for the broader community input in the formation of their final decisions. The use of the legislatively

created community school board seems a more than obvious vehicle for involving the wider community in such decision making. Yet unfortunately, rather than involving the community boards, the Chancellor and the City Board chose to leave the matter totally in the hands of the Commissioner of Health. While this may not have been in violation of statutory or discretionary authority, it certainly bespeaks the hostile attitude historically displayed towards community participation since the inception of the decentralization process.

Petitioners have thus failed to demonstrate any violation of statutorily mandated exclusion of children with AIDS from school or public hearings prior to respondents' announced policy recommendations. This, then, is the proper place to consider the second aspect of mandamus, which permits the review of the factual bases of respondents' discretionary policy of non-exclusion. The burden of proof is on the petitioners. (*Matter of Grossman v. Rankin*, 43 NY2d 493, 502.) The appropriate standard of review, "the arbitrary and capricious test," the Court of Appeals in *Matter of Pell v. Board of Education* (34 NY2d 222) stated at page 231:

"...'relates to whether a particular action should have been taken or is justified ... and whether the administrative action is without foundation in fact.' ... Arbitrary action is without sound basis in reason and is generally taken without regard to the facts." (See, also, *First District Dental Soc. v. Sencer*, 116 Misc 2d 528.

In *Matter of Grossman v. Rankin* (*supra*), the Court in commenting on the role of the trial court in eliciting the factual basis underlying the Agency determination, stated at page 503:

"To aid in satisfying its burden [petitioner's burden of proof] a *de novo* review of the basis for the administrative action was undertaken, and any competent and relevant proof is admissible to show that the underlying material on which the commission based its determination has no basis in fact (*Matter of Mandle v. Brown*, 5 NY2d 51, 65; see, 8 Weinstein-Korn-Miller, NY Civ Prac, pars 7803.10, 7803.11). In the instant matter, the Trial Term allowed ample range of proof with respect to the validity of the commission's action ..."

It is not, however, within the scope of the court's review to weigh

conflicting evidence and substitute its judgment for that of the Agency. In *City of Rome v. State Health Dept.* (65 AD2d 220), the court stated at page 225:

"To a large extent, petitioner's claim that the order is unfounded is based less upon the absence of evidence to support the several findings of the hearing officer than it is upon the hearing officer's apparent refusal to give weight to petitioner's conflicting evidence. In adopting that approach, petitioner misconceives our function in article 78 proceedings. The doctrine is well settled that the court is without power to upset the determination of an administrative tribunal on the question of fact and thus we may not accord differing weight to conflicting evidence (*Matter of Pell v. Board of Educ., supra*, p. 230; *Matter of Colton v. Berman*, 21 NY2d 322, 329, *supra*). (See, also, *Matter of Canfora v. Board of Trustees*, 90 AD2d 751, aff'd 60 NY2d 347; *Matter of Christian v. New York City Employees Retirement System*, 83 AD2d 507, aff'd 56 NY2d 841.)"

The court notes that the use of broad police power to protect the public health, safety and welfare may to some extent interfere with liberty or property. This is appropriate only where the court determines that the action is reasonably connected to and will in fact promote the public health or safety. (*Matter of Viemeister*, 179 NY 235, 238; see, also, *LaRocca v. Dalsheim*, 120 Misc 2d 697, 708-9.) This principle underlies all of the legislation and health and sanitary code enactments relating to preventing the spread of communicable diseases by measures pursued without regard to the consent of the individual concerned, as exemplified by the decisions relating to the compulsory immunization law against poliomyelitis, smallpox and measles in the public schools. (See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11; *Matter of Viemeister, supra*; *McCartney v. Austin*, 31 AD2d 370; *Matter of Elwell*, 55 Misc 2d 252; see, also *Chiropractic Assn. of NY v. Hilleboe*, 12 NY2d 109, 115.) As stated by the Court of Appeals in *Matter of Viemeister* (*supra*, pp 238-239, 241) in upholding the Public Health Law mandate that children not immunized against smallpox shall be excluded from school:

"A statute entitled a health law must be a health law in fact as well as in name, and must not attempt in the name of the police power to effect a purpose having no adequate connection with the common good. As we have recently said, 'it must tend in a degree that is perceptible and clear towards the preservation of the

. . . health . . . or welfare of the community, as those words have been used and construed in the many cases heretofore decided" (*Health Dept. of N.Y. v. Rector, etc.*, 145 N.Y. 32, 39) . . .

"The right to attend the public schools of the state is necessarily subject to some restrictions and limitations in the interest of the public health. A child afflicted with leprosy, smallpox, scarlet fever *or any other disease which is both dangerous and contagious*, may be lawfully excluded from attendance so long as the danger of contagion continues. Public health as well as the interest of the school requires this, as otherwise the school might be broken up and a pestilence spread abroad in the community. So a child recently exposed to such a disease may be denied the privilege of our schools until all danger shall have passed. Smallpox is known of all to be a dangerous and contagious disease. If vaccination strongly tends to prevent the transmission or spread of this disease, it logically follows that children may be refused admission to the public schools until they have been vaccinated." (Emphasis added.) . . .

"While we *do not decide and cannot decide* that vaccination is a preventive of smallpox . . . we hold that the statute in question is a health law, enacted in a reasonable and proper exercise of the police power. It operates *impartially* upon all children in the public schools and is designed not only for their protection but for the protection of all the people of the state." (Emphasis added.)

Respondent Sencer concedes that under his broad power and discretion to protect the public health and to prevent the spread of disease (NYC Charter, section 556; NYC Health Code, section 3.01), he has the *discretionary authority* to conclude, as petitioners strongly urge, that AIDS is communicable in the classroom setting, or that a child with AIDS in the classroom would promote the spread of the disease, requiring exclusion of that child from school. His refusal to exercise that discretion in that direction must be examined against the record and the standards of review established by law.

Apart from the general body of medical knowledge concerning AIDS, as previously discussed, the CDC, New York State and other states, and all but one of the expert witnesses at trial agree with the policy of the Commissioner not to exclude children with AIDS from school unless their physical, neurological,

developmental or behavioral condition makes it necessary for them to be educated in a more restricted setting. Although Drs. Giron and Rubenstein qualified their opinions with the condition that adequate precautions be taken, they, as well as the expert witnesses called by respondents, concluded that children with AIDS should not automatically be excluded from school. That conclusion is consistent with the epidemiological evidence, including the family and health-care worker studies, which show that there is essentially no risk of transmission of HTLV-III/LAV in the classroom setting.

The CDC, New York and other states that have issued guidelines and policy recommendations similarly conclude that children with AIDS should not, absent exceptional circumstances, be excluded from school.

The CDC's recommendations provide, in pertinent part:

"2. For most infected school-aged children, the benefit of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting."

The Connecticut guidelines provide:

"2. As a general rule, a child with AIDS/ARC should be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges and services provided by law and local policy of each school district."

And the New Jersey guidelines provide:

"1. Children entering grades K through 12 with AIDS/ARC or HTLV-III antibody shall not be excluded from attending school unless the following exceptional conditions are evident: a) The student is not toilet-trained or is incontinent, or otherwise is unable to control drooling; b) Is unusually physically aggressive, with a documented history of biting or harming others."

Taking a more conservative approach, the only expert witness to

conclude that no children with AIDS should be permitted in school was Dr. Resnick, who was not an epidemiologist, had done no research on the issue of the transmissibility of HTLV-III/LAV, and conceded his lack of familiarity with the findings derived from the studies of family members and health-care workers. His disagreement with the CDC and epidemiologists, therefore, was not based on any evidence that HTLV-III/LAV could be transmitted in the classroom setting, but only on what he described as a "philosophical difference" as to the sufficiency of the data "at this moment in time."

With respect to petitioners' implication that the CDC's reference to "biting" and "uncoverable oozing lesions" reflect a real concern by the CDC for the risks of HTLV-III/LAV transmission in the school setting, it would be misleading to promote such a notion since the CDC's guidelines make clear that the "theoretical potential" for transmission by these means among younger children and some neurologically handicapped children derives from experience "with other communicable diseases."

Throughout this case, petitioners focused their point of attack upon the reluctance of the medical experts to unequivocally state with certainty that HTLV-III/LAV cannot be transmitted except through previously identified routes of transmission. The testimony reflects, however, that it is not in the nature of medical science to be governed by a "no risk" standard. In stating his view that imposing a "no risk" standard upon medicine generally would effect "utter paralysis" upon the treatment of disease and medical research, Dr. Cooper suggested some useful examples in keeping a proper perspective regarding risks:

"It's hard for me to conjure up any of the important prevention or treatment activity that we engage in that is risk free. Whether it's the risk associated with polio immunization, where we know that we have changed dramatically the health of the United States and much of the world, where we know that out of every million doses of polio vaccine that we give that perhaps there will be one case of vaccine-associated paraletic disease and that in fact the case may not be of the vaccine but may be the case of the vaccine, that risk of about one in a million.

"So the risk that we accept in our hospitals every day where every patient who undergoes general anesthesia, is at risk of an

anesthetic accident, and that's in the range of a few thousand, or the risk of serious allergic reaction to penicillin which may be fatal. We accept risk. Hopefully balancing the risk wisely with the potential benefit."

Understandably, the public, not recognizing the underlying medical tradition, is suspicious of the seeming uncertainty. Yet, the fact that some laypeople, both learned and unlearned, and some physicians of great skill and repute, may differ as to the efficacy and necessity for excluding from the regular classroom setting the HTLV-III/LAV-infected child who otherwise demonstrates a normal physical, neurological, developmental and behavioral condition, is not reason enough to declare the Commissioner's policy to be without consideration or in disregard of the facts. As stated in *Matter of Viemeister* (*supra*, p. 241): "The fact that the belief is not universal is not controlling, for there is scarcely any belief that is accepted by every one. The possibility that the belief may be wrong and that science may yet show it to be wrong is not conclusive . . ."

Since "the apparent nonexistent risk of transmission of HTLV-III/LAV" in the school setting finds strong support in the epidemiological data accumulated over the five years of experience with this disease, as exhaustively explored on the record, and because the *automatic* exclusion of children with AIDS from the regular classroom would effect a purpose having no adequate connection with the public health, safety or welfare, it would usurp the function of the Commissioner of Health if this court adjudged, as a matter of law, that the non-exclusion policy was arbitrary and capricious or an abuse of discretion simply because in the court of public opinion, that particular policy was—perhaps, or possibly—not the best choice. Although this court certainly empathizes with the fears and concerns of parents for the health and welfare of their children within the school setting, at the same time it is duty-bound to objectively evaluate the issue of automatic exclusion according to the evidence gathered and not be influenced by unsubstantiated fears of catastrophe. (See, e.g., *Matter of Fannie Mae Jackson v. New York State Urban Devel. Corp.*, 110 AD2d 304.)

Finally, automatic exclusion from school of all children with AIDS would violate their rights under the Rehabilitation Act (See 29 U.S.C. section 794) and to equal protection of the laws.

Given that the question of excluding children with AIDS from school has only recently generated legal activity, it is not at all unusual that the best available legal authority is found in two federal appellate decisions concerning other communicable diseases (hepatitis B and tuberculosis).[11] Six years ago, the Federal courts prevented the New York City School Board from limiting the school attendance of some 50 retarded children infected with hepatitis B. (*New York State Assn. for Retarded Children, Inc. v. Carey*, 466 F Supp 479 [E.D.N.Y.], affd 612 F2d 644 [2d Cir. 1979], *supra*.) In *Carey*, following a report (ultimately proved incorrect) of a hepatitis B outbreak in elementary schools, the New York City Board of Education summarily excluded from the public schools approximately 50 mentally retarded children—of whom 42 were former Willowbrook residents integrated into the public school system as mandated by a Consent Judgment—based upon the epidemiological classification of the children as carriers of hepatitis B.

After this exclusionary policy was enjoined, the Board, under pressure from parents of non-carrier children and fear of adverse publicity, formed a task force to devise and implement a plan consistent with the Department of Health guidelines recommending segregation within the public schools of hepatitis B carriers from non-carriers. Because a consensus could not be reached among the task force members on the necessity for separation of the carrier children, the Board formulated its own plan predicated, *inter alia*, on mandatory segregation of carriers from non-carriers and individualized evaluation of each child's personal educational needs, subject to parental review. The Board then unsuccessfully moved in the District Court for a declaratory judgment establishing the legality of its plan. The District Court held, in two separate opinions, that either exclusion or isolation of these students would violate their rights under the Rehabilitation Act, the Education of the Handicapped Act, the New York Education Law, and the Equal Protection Clause of the Fourteenth Amendment. (*New York State Assn. for Retarded Children, Inc. v. Carey*, 466 F Supp 479 [E.D.N.Y., 1978], *supra*; *New York State Assn. for Retarded Children, Inc. v. Carey*, 466 F Supp 487 [E.D.N.Y., 1979].)

Based on "the inability of the Board to offer any evidence of even one instance of actual transmission of the virus within the classroom setting";[12] the fact that not one instance of hepatitis

B transmission had been reported in the three-year period since the placement of 130 hepatitis B carriers in community and family homes "in which contact is likely to be at least as intimate as it is in the classroom—if not more so"; the relevant federal and state guidelines, together with the testimony, indicating that proper hygienic practices, classroom management and structure, and increased training of teachers and staff are sufficient to substantially reduce the risk of transmittal; and testimony of the deleterious, traumatic effect that exclusion or isolation would have upon these children, the District Court summed up its findings (*New York State Assn. for Retarded Children, Inc. v. Carey*, *supra*, pp. 499-500.):

"Without requiring that the Board clearly demonstrate existence of a significant health risk, we cannot countenance depriving these retarded children of the benefits to be gained by association with other children, handicapped and non-handicapped, nor can we permit any action which, by its stigmatizing consequences, would irreparably disrupt their educational development. In view of the availability of less drastic prophylactic measures which might be adopted ... the proposed segregation seems an unwarranted and unnecessarily restrictive reaction to the purely theoretical risk of transmission that the Board has shown."

In affirming, the Court of Appeals for the Second Circuit stated at page 649:

"The New York City Board of Education is a recipient of federal funds. The children in this suit are clearly handicapped within the meaning of Section 706(7) [Rehabilitation Act]. They were excluded from regular public school classes and activities 'solely by reason of their handicap,' since only mentally retarded youngsters who were carriers of the hepatitis B antigen were isolated; no effort was made to identify and exclude normal children who were carriers. Section 504 is thus fully applicable to this case."

The court then went on to consider whether in the face of a prima facie showing of discrimination the Board of Education could establish any factual justification for the plan and rebut the inference of illegality, concluding at page 650:

"At trial, the Board was unable to demonstrate that the health

hazard posed by the hepatitis B carrier children was anything more than a remote possibility. There has never been any definite proof that the disease can be communicated by non-parenteral routes such as saliva. Even assuming that there were, the activities that occur in classroom settings were not shown to pose any significant risk that the disease would be transmitted from one child to another."

The court further acknowledged, however, that in view of the rapidly expanding medical knowledge, should new facts warrant a different result at some point in the future, the Board would not be barred from returning to court with evidence to support any plan appropriate to a significant health risk.

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. section 794) provides, *inter alia*:

"No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this table, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance ..."

A handicapped individual is:

"... any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such impairment." (29 U.S. C. section 706[7][B].)

The regulations that have been promulgated under the Rehabilitation Act define "physical or mental impairment" to mean:

"(A) any physiological disorder or condition, ... affecting one or more of the following body systems: ... hemic and lymphatic ..." (34 C.F.R. section 104.3[j][2][i][A].)

Since HTLV-III/LAV destroys certain lymphocytes, a person with AIDS clearly has such a "physical impairment". Further, the regulations define the phrase "is regarded as having an impairment" to mean any person who:

"(A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient [of federal funds] as constituting such impairment; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in this section but is treated by a recipient as having such an impairment." (34 C.F.R. 104.3[j][2][iv].)

If students with AIDS were automatically excluded from school, they would clearly be "treated ... as having such an impairment" by the Board of Education, a "recipient" of federal funds. Accordingly, children with AIDS are handicapped within the meaning of the Rehabilitation Act. (See, also, *People v. 49 W. 12 St. Tenants Corp.*, NYLJ, October 17, 1983, p 1, col 1 [Supreme Ct., New York County].)

The Rehabilitation Act would equally apply to a child such as John/Jane Doe who, by evidencing past infection with HTLV-III/LAV, "has a history of, or has been misclassified as having, a ... physical impairment that substantially limits one of more major life activities" (34 C.F.R. section 104.3 [j][2][iii]), or, by exclusion, would be "treated ... as having such an impairment."

More recently, the 11th Circuit Court of Appeals held that a teacher's susceptibility to tuberculosis constituted a "handicap" and that because the school system received federal funds, the teacher had to be accommodated under section 504. (*Arline v. School Bd. of Nassau County*, 772 F2d 759 [11th Cir. 1985].) In reaching its conclusion that Congress implicitly intended to place contagious diseases within the coverage of the Act, finding no legislative direction to the contrary, the Court noted (*supra*, p. 764):

"When a fact pattern falls so neatly within the statutory and regulatory framework, and when coverage would so clearly serve to promote Congress' intent to reduce instances of unthinking and unnecessary discrimination against those who are the focus of the statute's concern, we would be hard pressed to find an exemption without further legislative direction."

When one considers that several medical experts described the hepatitis B virus as "far more contagious" than the AIDS virus, the failure of proof in this case is even greater than that ex-

perienced by the Board of Education in *Carey*: petitioners not only failed to establish that the transmission of HTLV-III/LAV in the classroom setting is anything more than a remote theoretical possibility and that the Doe child engaged in any form of behavior that poses even a theoretical risk, their own witnesses did not dispute the testimony, as well as the federal and state view, that any theoretical risk can be substantially reduced by routine precautions. Accordingly, if the policy were to have been the exclusion of children diagnosed as having AIDS while not excluding children with ARC or those merely infected with the HTLV-III/LAV virus, it would constitute discrimination under section 504 of the Rehabilitation Act. Thus, the policy of non-exclusion would appear to have been correct. Since there is no prima facie showing of discrimination here, the burden is not on the agencies to validate their policy.

This ultimately brings us to the issue of whether the exclusion of known children with AIDS without imposing a similar policy on children with ARC or those who are asymptomatic carriers of HTLV-III/LAV would constitute a violation of the Equal Protection Clause of the Fourteenth Amendment.

With the recent medical finding by the second panel that, the Doe Child "does not at this time meet the CDC surveillance definition of AIDS, but has been infected with the HTLV-III virus ... [and] has clinical and laboratory evidence that put him/her in a category of immune suppression," the child's attorney asserts that to impair Doe's right to an education would violate his/her right to equal protection of the laws.

Public education is not a fundamental "right" granted to individuals by the United States Constitution. (*San Antonio Independent School Dist. v. Rodriquez*, 411 US 1, 35 [1973].) However, once the state, like New York, chooses to provide public education (New York Constitution, Art 11, section 1), the right to an education "must be made available to all on equal terms". (*Brown v. Bd. of Educ.*, 347 US 483, 493 [1953].) While the denial of attending the school of one's choosing is not tantamount to a denial of a right to education (*Johnpoll v. Elias*, 513 F Supp 430, 432 [E.D.N.Y.]), the legal system recognizes education's impact upon the "social, ... intellectual and psychological well-being" of the child (*Plyer v. Doe*, 457 US 202, 222 [1982]), and the benefits the child derives from the socialization process

in the regular classroom. (*Hairston v. Drosick*, 423 F Supp 180, 183 [S.D.W. Va. 1976].)

Absent any rational basis for petitioner's proposed exclusion of only known AIDS cases or carriers of the virus, without imposing such exclusion in the case of ARC patients or asymptomatic carriers who are as likely to present a risk of contagion because they too are infected with HTLV-III/LAV, such a proposal must be deemed a denial of the equal protection of the laws. In this respect, the parallels between this case and *Carey* are striking.

In *Carey*, as here, the evidence established that there were substantial numbers of children in the school system who were infected with the virus and who were not being excluded or isolated. The District Court held that the constitutionality of the Board's proposal could not be sustained because "among the approximately 1,000,000 children in New York City's public school system, no other group is tested for hepatitis B, nor is any action planned to identify or take special precautions with respect to any hepatitis B carriers other than those who are retarded." (*Carey*, *supra*, p 504.) Accordingly, the District Court concluded, the segregation of retarded hepatitis B carriers lacked any rational basis and violated their equal protection rights. Similarly, in this case, an estimated 500,000 persons, of whom 200 to 2,000 are school-aged children, in New York City, are asymptomatic carriers of HTLV-III/LAV; these persons are as likely to transmit the virus as a victim of AIDS. Because of the shortcomings of the antibody test and the social implications of a mandatory screening program, none of the medical experts, including petitioner's expert virologist, Dr. Resnick, recommended blood testing of all New York City school-aged children for the virus to determine whether they should be in school. In addition, not only is there no reporting requirement for ARC or asymptomatic carriers, based upon the lack of any evidence that more than a remote theoretical possibility of transmittal exists within the school setting, as well as the recommendation by both the Centers for Disease Control (Recommendation 9) and State Department of Health (Recommendation 1) that mandatory screening as a condition for school entry "is not warranted based on available data," there is no program for testing and identifying students, teachers, cafeteria workers or other school personnel infected with the virus, nor is there a requirement that such persons be reported to the Health Department.

It is difficult to conceive of a rational justification imposing a discriminatory burden on known carriers of HTLV-III/LAV while untested and unidentified carriers still remain in the classroom where they pose the same theoretical (though undocumented) risks of transmitting the virus to normal children.

VI

Petitioners question whether there are adequate precautions in effect in the public schools to guard against any theoretical risk of transmission and to protect the health of the children with AIDS.

The medical experts and the guidelines of the CDC, New York, and other states that have addressed the issue are in agreement in recommending that, because there may be undiagnosed cases of HTLV-III/LAV infection and other diseases which can theoretically result from exposure to infected blood and body fluids (e.g., hepatitis B), all schools, regardless of whether children with HTLV-III/LAV infection are attending, should adopt "routine procedures" for handling blood or body fluids.

The gist of the CDC recommendations is to urge personnel to avoid exposure of open skin lesions or mucous membranes to the blood or body fluids of *any* child. Containment of bloody articles, and good handwashing practices are recommended, as is the use of gloves if open lesions are present on the caretaker's hands. Soiled surfaces should be promptly cleaned with the disinfectants, such as household bleach.

Petitioners submit that Chancellor Quinones and Dr. Sencer initially chose to ignore the CDC recommendations in this regard and not to even consider adopting any routine procedures for the handling of blood or body fluids. The contention is that the various precautionary measures implemented and educational efforts undertaken since the beginning of the school year—amending Department of Health's Manual of Procedures for elementary and junior high schools to add sections on care of human bites and the procedures for cleaning soiled surfaces [September 23, 1985]; issuing updated First Aid Chart, which now provides specific instructions for the management of biting injuries (soap and water followed by alcohol swab) and the cleaning of soiled surfaces [October 1, 1985]; distributing

alcohol swabs to local districts; providing gloves to all teachers who wish to have them; holding two-hour informational forum for all Board of Education employees [October 28, 1985]—came about solely because of this litigation. This implies, however, that *no* policies and practices were in place in the New York City school system at the time Dr. Sencer made his decision to allow children with AIDS to remain in school. Such an implication amounts to a gross distortion of the facts. Indeed, not only were policies in effect which conformed, for the most part, to the routine and standard precautionary measures considered by the medical experts to be adequate to guard against any possibility of transmission, but *additional* precautions and policies (as previously delineated) were implemented to protect against any theoretical risk of transmission of HTLV-III/LAV in a school setting by such occurrences as biting or exposure to infection.

The belief that to some extent, the implementation of these additional precautions has been influenced by this proceeding, rather than an actual concern for the risk of transmission from these routes, or that New York's approach is inferior to that of other states, is of absolutely no relevance to the issue of an abuse of discretionary authority. The CDC guidelines were intended merely to provide the minimum necessary precautions for safety based upon available epidemiologic information. Thus, it is not unusual that various states around the country have had different responses to the guidelines and have adopted some regulations of their own. While some states and localities, such as Connecticut and New York City, have now developed procedures to a degree more restrictive than recommended by the CDC, others have accepted the CDC guidelines.

While this court neither possesses the medical competence to evaluate each and every prophylactic measure adopted by the respondents, nor is empowered to substitute its judgment concerning these matters for theirs, or to police the school system to verify that these routine procedures are being carried out, one would hope that the experience with the patterns of HTLV-III/LAV transmission so far, as established in court, would give reassurance to a wary but now, hopefully, informed public that the precautions that are in place or are in the process of being implemented throughout the school system to guard against any theoretical risk of transmission are more than adequate.

In sum, in light of these precautions and the educational effort

to advise school personnel how to manage biting and bleeding injuries, the continuing decision to permit a child reported to have AIDS to attend public school is founded on a rational basis and therefore cannot be deemed arbitrary and capricious.

VII

The guidelines issued by the CDC and the New York State Department of Health, the policy of the New York State Education Department, and the expert witnesses on both sides endorse the view that children with AIDS should be permitted to attend school after a case-by-case review to determine whether circumstances exist that would tend to pose increased risks to others or require special precautions.

Both the CDC (Recommendation 1) and the State Health Department (Recommendation 2) recommend:

"Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the *team approach* including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed." (Emphasis added.)

Similarly, the policy of the State Education Department, as stated by Commissioner Gordon M. Ambach on September 4, 1985, is that:

"... no child be excluded from school attendance solely because the youngster has been diagnosed as infected with AIDS. Instead, school authorities should review each case individually with the appropriate medical personnel and the child's parents to determine whether the youngster can be accommodated in a normal education setting without undue risk to himself or others."

In addition, there was virtually unanimous agreement among the expert witnesses with the case-by-case approach. Only Dr.

Resnick disagreed that such an approach would be effective since, in his opinion, there could be no "guarantee" that a child with AIDS would have no predilection to engage in the kinds of activities which theoretically could communicate the disease. That opinion was consistent with Dr. Resnick's previously expressed "philosophical" preference for "the conservative approach."

Dr. Sencer also disagreed with the CDC proposal for committee review, not due to his lack of faith in the ultimate determination, but rather because he viewed the CDC's concern regarding the theoretical risk of HTLV-III/LAV transmission through the bodily fluids of infected children as irreconcilable with the available immunologic and epidemiologic evidence concerning AIDS. In questioning the necessity for such a committee, Dr. Sencer opined that, in the absence of any evidence for transmission of AIDS in the school setting, the education and placement of a child with this condition or related conditions, should be, as for all children, determined by the child's own family or treating physician solely on the basis of the child's needs, health status, and learning level. This very premise was incorporated in the proposed City guidelines undergoing review during the summer of 1985, which from first to final draft never included the notion of a committee case-by-case analysis. Nevertheless, to "augment" the confidence and education of the public, as he put it, the Commissioner decided to create a multi-disciplinary panel as suggested in Recommendation 1 of the CDC's guidelines.

At the outset, the court notes that the petitioners do not question the concept of a committee to review school-aged children with AIDS or related conditions, or the substance of the recommendation by both advisory panels that the Doe child not be removed from the regular classroom. The evidence established without contradiction that the original four-member panel considered the appropriate factors suggested by the CDC guidelines and that, based upon the information gathered and the stipulated facts, the child in question was normal in every relevant respect and was not a biter, and that there was nothing special about his/her condition that required exclusion from school. These findings were confirmed by the second medical advisory panel. The specific facts and circumstances as to this child thus supported both panels' recommendation and the Commissioner's ultimate determination that the Doe child be permitted to continue in school.

In their brief, however, petitioners challenge (1) the appropriateness of referring a student with AIDS to a Department of Health constituted-committee rather than the local school district's Committee on the Handicapped, and (2) the composition and procedures of the first panel.

The court begins by addressing petitioners' contention that the case-by-case inquiry of children suspected of having AIDS should have been conducted by referral to the local school district's Committee on the Handicapped rather than through the device of an advisory panel appointed by respondent Sencer. The Education of the Handicapped Act (20 U.S.C. section 1400 et seq.) was enacted in 1975 to:

"Assure that all handicapped children have available to them ... a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of handicapped children and their parents and their guardians are protected, [and] to assist States and localities to provide for the education of all handicapped children ..."

A similar concern was expressed by the New York State Legislature in enacting legislation relating to handicapped children. (Education Law, section 4401, et seq.) In New York, the mechanism for securing appropriate special education programs and services for handicapped students is by a referral to the local district's Committee on the Handicapped, a multidisciplinary team established in accordance with the provisions of section 4402 of the Education Law. The pivotal question is whether a child diagnosed as having AIDS would fall within the definition of a "handicapped child." Evidently, the term is more narrowly defined in the Education of the Handicapped Act than the Rehabilitation Act. Under the Education of the Handicapped Act, the term includes those children evaluated as being health impaired who, because of those impairments, need special education and related services. (20 U.S.C. section 140[a][1].) "Health impaired" is defined as "having limited strength, vitality or alertness due to chronic or acute health problems ... which adversely affect a child's educational performance." (34 C.F.R. section 300.5[b][7].) Section 4401(1) of the Education Law defines a "child with a handicapping condition" as one "who, because of mental, physical or emotional reasons can receive appropriate educational opportunities from special

services and programs ..." Thus, while a child with AIDS could become handicapped as a result of deterioration in his or her condition, the evidence clearly supports the determination that such children are not handicapped for purposes of referral to a Committee on the Handicapped merely because they have AIDS/ARC or are infected with the HTLV-III/LAV virus. To hold otherwise would be tantamount to publicly fostering the picture of such children as "damaged goods."

Unlike the Committee on the Handicapped, the original advisory panel was not created by statute nor were there any regulations mandating the precise composition of the panel or methods of evaluation. Because its genesis was the CDC's recommendation that the "term approach" be utilized to review on a case-by-case basis each HTLV-III/LAV-infected school-aged child, it is important not to overlook the fact that the CDC guidelines were made available "to *assist* state and local health and education departments in developing [their own] guidelines." (Emphasis added.) They were intended not to be restrictive, but instead, adaptable to specific local situations. This is borne out by the liberal provisions governing the composition of "the team," giving the governmental agencies great latitude in the selection process. In the State of New Jersey, for example, the Department of Health, upon consideration of the CDC guidelines, opted for a very different approach from that of New York City: an "expert Medical Advisory Panel" has been established "to individually evaluate," after referral by the County Superintendent of Schools, "those AIDS/ARC or HTLV-III antibody positive children" deemed by a local school board to exhibit certain exceptional behaviors or symptoms which would justify exclusion; that Panel's determination is preceded by an adversary-type hearing at which the school district seeking review must "bear the burden of proof ..."

Thus, notwithstanding petitioners' contention regarding the so-called dissimilarity between the original panel constituted by Dr. Sencer (which included medical and school professionals and a parent leader) to the one described in the CDC guidelines, from the foregoing discussion, it is apparent that Dr. Sencer was under no statutory or regulatory mandate to ever create a review panel, or, having voluntarily adopted such an approach, to appoint members with certain backgrounds, experience and expertise, or from various constituencies. Accordingly, what amounts to nothing more than mere displeasure by petitioners with the

credentials and qualifications of the original four-member panel, cannot be translated into arbitrary and capricious action by the Commissioner of Health.

Insofar as the petitioner's challenge to the procedures followed by the first panel, here too, absent any precise methods of evaluation against which to measure Dr. Sencer's decision as to how the panel was to proceed, it was not arbitrary and capricious for the Commissioner to rely upon his own judgment in prescribing for the panel the process for reviewing individual cases.

Although it would not otherwise be necessary to reach the issue, generally speaking, of the appropriate methods of evaluation, nevertheless, there were certain deficiencies in the procedure followed by the first panel which warrant consideration in any future revisions of the process. It should be emphasized, however, that this slight intrusion upon the prerogative of the Commissioner is not an attempt by this court to regulate on its own. The court well recognizes that this is an area beyond the circumference of one private lawsuit. (cf. *Boomer v. Atlantic Cement Co.*, 26 NY2d 219, 223.)

The major shortcoming in the panel's procedure was in its almost total reliance upon the underlying personal and medical data, as orally reported by the treating physicians who in turn retrieved much of their non-medical behavioral data from the parents (e.g., biting, physical aggression). It is highly questionable, therefore, whether the panel actually made an "independent determination," as contended by respondents, or merely acted as "a conduit of the doctor's judgment, ... rendering no further judgment of [its] own," as was stated by Dr. Thomas (the only member of the panel to testify). The respondents contend that there was no need for the panel to examine the children, since it is acceptable medical practice to rely on the oral report of a treating physician, especially where, as in the case of this child, the treating physician was known to be reliable and experienced with AIDS. In addition, they maintain that the decision not to invite the child's physician or parent before the panel was supported by the need to prevent the child's identity from being revealed. (This latter contention will be discussed in the section on disclosure [*infra*, XIII].)

In this court's view, there are several reasons why it seems more

appropriate not to rely exclusively on the underlying data furnished by the child's physician and parent. First, because infection with HTLV-III/LAV may result in a spectrum of medical conditions of differing severity, even the available evaluative information of a physician experienced with AIDS may not indicate a clear diagnosis in order for the record to support an appropriate determination. Second, given the relatively few treating physicians with background, experience, and expertise in this field, the panel should have the responsibility to independently determine the validity of the examination results obtained by a treating physician before it adopts them, rather than merely defer to the evaluation data from the physician or parent. Third, the panel should invite the appropriate professionals most familiar with the child's medical history to attend any meeting concerning the appropriate placement for such a child. Fourth, the panel should strongly consider, where appropriate, having the child independently evaluated for neurological and psychological disorders. Finally, an adversary-type proceeding, similar to that employed in New Jersey, might serve the worthwhile purpose of bringing the local school district into the evaluation process.[13]

In addition, since the panel is ultimately determining the educational placement of the child, it must adhere to the minimum procedural safeguards required by the Due Process Clause. (cf. Education Law, section 4404; 8 NYCRR 200.5; *Johnpoll v. Elias*, 513 F Supp 430, 431, *supra*; see, generally, *Goss v. Lopez*, 419 US 565, 574 [1974].)

Of course, only time will tell whether revision of the review process, both in scope and procedure, will instill public confidence in the evaluations and determinations that eventuate. Certainly the current composition and procedures of the original panel have undeniably failed to evoke the confidence of or to educate the public, as was intended by the Commissioner of Health. As precisely stated by Dr. Cooper: "... [I]f one of the expected outcomes of any public process is public trust and comfort and security about outcome, then, in hindsight that process didn't achieve that goal."

While the court recognizes that the judicial interpretation of publicly disseminated statements has no import or relevance to this proceeding, some final observations on this subject are in order.

Petitioners contended throughout the trial that the function of the "specially constituted committee" announced in the joint statement released on August 30, 1985, had been misrepresented. The petitioners maintain that this announcement left the distinct impression that the committee was to consider the "health and education interests of the children ... who do not have AIDS" (par 7), i.e., the risk of transmitting the disease to those children. In this connection, respondents argue that the petitioners' attack on the first panel is based essentially on their "misconception" as to its function. Quoting themselves from paragraph "7" of the August 30 release, respondents aver that the panel's function was to determine "whether, given the health and development of the children [with AIDS], the child [with AIDS] should be educated in a setting other than school." They further reiterate the fact that the basic public policy decision not to automatically exclude children with AIDS from school was made by Dr. Sencer *before* the panel was appointed.

As established by the testimony and reflected clearly in the guidelines for the 1985-1986 school year being formulated through the joint efforts of the Health Department and Board of Education, and particularly the final draft completed by August 26, 1985, we now know that the policy of fully integrating children with AIDS or related conditions into the public schools was decided upon by the Commissioner before August 30, 1985, certainly no later than in June, 1985, following the CDC meeting attended by Dr. Thomas, at which there was virtually unanimous agreement that children with AIDS/ARC or infected with HTLV-III/LAV virus could attend school. Therefore, the joint statement (which issued out of the Office of the Mayor) represented the first so-called official pronouncement of that policy. This being the situation, the petitioners, no less the public-at-large, had good reason to be confused about the panel's function, for the statement lacked clarity of purpose, and furthermore, avoided stating unequivocally (much unlike Commissioner Ambach's release) that, "no child be excluded from school attendance solely because the youngster has been diagnosed as infected with AIDS." Most unfortunately, any misconception that this highly ambiguous statement may have generated was likely only exacerbated when just two days thereafter the Mayor ventured to express a policy view seemingly *in direct conflict* with that of his appointed officials.

VIII

Cases of AIDS are reported to the Department pursuant to the reporting requirements set forth in the State Sanitary Code (10 NYCRR Part 24) section 24.1, which provides in pertinent part:

"All cases or suspected cases of Acquired Immune Deficiency Syndrome (AIDS) shall be reported to the Commissioner of Health by city, county and district health officers, physicians, hospital administrators, laboratories or persons in charge of state institutions."

Section 24.2 of that regulation requires that "such reports and additional information shall be kept confidential, as required by Public Health Law, section 206(1)(j)."

Public Health Law, section 206(1)(j) provides in pertinent part:

"The Commissioner shall ... cause to be made such *scientific studies and research which have for their purpose the reduction of morbidity and mortality.* ... In conducting such studies and research, the commissioner is authorized to receive reports on forms prepared by him ... *Such information when received by the commission ... shall be kept confidential and shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits.*" (Emphasis added.)

The Legislature in enacting section 206(1)(j) of the Public Health Law created a comprehensive and impervious shield to protect the ability of the Health Department to conduct essential scientific research and medical audits. In explicit language, the statute provided that information received from participants in health studies or audits would be kept confidential, even from judicial process. This statutory commitment of confidentiality is designed to effectuate two important public policies of the State of New York: 1) protection of the privacy of its citizens and 2) creation of an atmosphere of trust to enable the Health Department to gather the kind of complete health data it needs to carry out its statutory purposes. (*Matter of Love Canal*, 112 Misc 2d 861, 863, affd 92 AD2d 416.)

The statute provides for no exception to these restraints. In *Matter of Love Canal* (*supra*, 92 AD2d 416), the court stated clearly

the unqualified nature of the confidentiality provision's prohibition against disclosure. There, the State Department of Health conducted an investigation of the Health complaints of the residents of the Love Canal area. As part of its investigation, the Department of Health distributed a questionnaire to the residents, obtained their medical records from physicians and hospitals and interviewed the residents.

Subsequently, many of the Love Canal residents brought actions against chemical companies for illnesses claimed to have been caused by exposure to toxic substances. The defendants sought disclosure from the State of the plaintiffs' responses to the medical questionnaires, the plaintiffs' responses to the medical records and other information obtained by the Department of Health. The defendants argued that the plaintiffs had waived any rights of confidentiality by commencing the litigations. The State, in opposing discovery, relied on the confidentiality provision of Public Health Law, section 206(1)(j).

Special Term held that section 206(1)(j) prohibited disclosure of the records in the possession of the Department of Health (*Matter of Love Canal*, 112 Misc 2d 861, *supra.*) In affirming, the Fourth Department stated at pages 422-423:

"We hold that the provisions of section 206 (subd 1, par [j]) are plain and unambiguous and that there is no doubt that the information imparted to the commissioner in the questionnaires, which were prepared and disseminated by him, falls within the statutory proscription. The questionnaires are confidential and not subject to disclosure no matter how strong the showing of need or relevancy (see *Cirale v. 80 Pine St. Corp.*, 35 NY2d 113). That is what the statute says. *The prohibition against disclosure is absolute. There are no qualifications, and no role in the disclosure of the information is given to plaintiffs* ...

"*This section*, which was designed as a shield to protect the ability of the Department of Health to conduct essential studies, *specifically prohibits the commissioner from violating the confidentiality attached to the records.* Plaintiffs' waiver of the physician-patient privilege is an inapposite consideration in the context of the *statutory direction that mandates the duty of nondisclosure to the Commissioner of Health. The individual plaintiffs cannot waive a privilege which does not belong to them.*" (Emphasis added.)

To the extent there may be any exception to the absolute confidentiality protection of Public Health Law, section 206(1)(j), such exception has been unequivocally limited to reports or records *other than* information imparted to the Commissioner of Health in connection with research or scientific studies designed to reduce "morbidity and mortality." Section 11.07 of the New York City Health Code (Confidentiality of Reports and Records), as amended, thus provides in pertinent part:

"(a) Reports and records of cases of Acquired Immune Deficiency Syndrome (AIDS) ... and records of clinical or laboratory examination shall not be subject to subpoena or to inspection by persons other than authorization personnel of the Department except as follows: ...

"(b) Such reports and records relating to Acquired Immune Deficiency Syndrome (AIDS) ... may be disclosed or inspected upon submission to the Department ... of a written consent ... [i]n ... cases involving such reports and records of minor patients, ... signed by the parent or lawful guardian of the child. *Under no circumstances shall epidemiological information relating to the control of Acquired Immune Deficiency Syndrome, ... be deemed reports or records under this section so as to subject said information to disclosure with or without consent* ...

"(c) Subsections (a) and (b) of this section shall not prevent authorized personnel of the Department from furnishing appropriate information ... to any person when necessary for the protection of health. A person, institution or agency to whom information is furnished or to whom access to records has been given under this section of law shall not divulge any part thereof so as to disclose the identity of the person to whom such information disclosure is necessary for the treatment of a case or carrier or for the protection of the health of others." (Emphasis added.)

The confidentiality provided by section 206(1)(j) guards the information gathered by the state and local public health agencies in carrying out their surveillance task. By this task, such agencies are charged with the responsibility of monitoring the progress of diseases which may be highly contagious or of epidemia proportions.

This is not the only task of public health agencies and may provide only a small portion of the data and records which they accumulated. (See, e.g., NYC Health Code, section 49.17 [School Medical Records].) Section 206(1)(j), however, provides absolute confidentiality to the *surveillance data* and does not deal with the records of the other tasks. The other records of the New York City Department of Health are guarded by the more limited confidentiality of section 11.07 of the New York City Health Code, and thus available for release upon the written consent of the parent or guardian of the minor child. It is noteworthy, however, that this section of the Health Code is consistent with Public Health Law, section 206 to the extent that it specifically exempts "epidemiological information" from disclosure with or without consent.

Respondent Sencer has never denied the fact that the information presented to the review by panels concerning identified school-aged children with AIDS, including the child who is now attending school, was obtained from the Department of Health through the reports made to its AIDS Epidemiologic Surveillance Unit. By his broad use of section 206, utilizing the AIDS surveillance information to identify individuals for panel review, Dr. Sencer came dangerously close to compromising the very data which that section was intended to protect. The data may be used for statistical purposes or for research and study of the epidemiology of the disease. Here, the data, in part, was revealed to both panels for determining the fitness of an individual to attend school. This appears to be a violation of the statute and thus a breach of confidentiality. If this be correct, then any additional data collected by the panels would not be surveillance data and not protected by section 206. It might be argued that the problem would never come about as the data would never be revealed. This would only be true if Dr. Sencer meant never to act on a possible committee recommendation that a teacher or some other school official be informed in a given case. This would render the panels a fraud. If on the other hand, Dr. Sencer intended affirmatively to act on such recommendation, then he intended a clear violation of section 206. Thus, the Commissioner's use of section 206 to create a wall of secrecy may have opened a Pandora's Box.

What, then, is the solution to this question? Clearly, the dictatorial imposition of a universal answer under the guise of statutory compliance is not it. The CDC guidelines suggest case-

by-case review of each child which must be sensitive to all the needs of the child including confidentiality. This is one of many possibilities. Such individual case review raises the additional question of how the identity of such individuals would be ascertained. *The use of surveillance data is not a permitted vehicle.* While the legislature could change this restriction, the court would discourage such action as it would adversely impact on the important task of tracking the history of certain diseases. Yet, whatever method for referral is eventually chosen, the decision as to whether and to whom the identity of the child should be revealed will ultimately reside with the review panel. The answer to these questions is not easy and the court will not succumb to the quick fix of choosing one.

Under the Constitution of this State, the resolution of such public policy questions must be the responsibility of the legislative and executive officials addressing it in an open forum.

COMMENTARY

While the court cannot say that the medical evidence supports petitioners' conclusions or that the respondents' actions are arbitrary or capricious, the court does not believe that the respondents are without fault. From the outset, it was clear that the respondents operated with a notion that they knew what was best and would make all the necessary decisions for everyone's good. Believing this, they acted in an imperious fashion, accepted little by way of inquiry, and no criticism.

This court cannot resist making some observations with regard to this situation. Fundamental to our system of government is the notion that officials govern with the consent of the people and that the people have the right to know what these officials are doing. In order to strengthen this flow of information, the legislation of this State has created a Freedom of Information Law and enacted other public access statutes. The respondents have taken great pains to establish that the letter of this legislation does not apply to this case. They have, however, missed the spirit of the law.

Confidentially in dealing with individual cases is unquestionably necessary. The development of city-wide policy behind the cloak of secrecy is hard to understand. Respondents base their action

on the excuse of not wanting to cause a panic. This excuse is not supported by any evidence. In any event, it is too facile a vehicle for avoiding seeking the consent of the governed. Some allusion has been made to the conduct of the petitioners and their constitutents, an ex post facto effort to show that a panic occurred. This court finds that the exercise of a constitutional right of protest cannot be classed as panic. The portrayal of parents as misanthropes because they disagree with respondents is unjustified. It is unfortunate that the petitioners and their constituents chose to use children on the picket lines and as part of a boycott. This conduct, however, is not unique in this society. In the ultimate, the conduct of the petitioners and their constituents disprove the mistaken notion of the respondents that the people cannot be trusted with the information they need to know to make reasonable decisions.

One would have thought that the time had long past when public officials would exhibit such insensitivity. Instead of educating and inspiring the confidence and trust of the public, respondents left them frustrated and hostile in the face of such an emotionally charged issue. It is these public officials themselves who predictably, although perhaps unwittingly, let loose the forces of anxiety and fear. Parenthetically, blame is to be borne as well by certain members of the medical community who by their professionally irresponsible and baseless characterizations of this disease as a "plague" only exacerbated the fears and fueled the passions. Where the issue was so compelling and the stakes nothing less than our progeny, the public should have been informed.

The result was a five-week trial during which this court, with the able assistance of eminent counsel, attempted to fill the educational void by surfacing information which should have been provided to the public as a matter of routine. Had the public officials involved trusted the people, much of this trial could have been avoided. Unquestionably, not all of the people would have agreed with any action taken by these public officials. In a democracy, unanimity is never to be expected. However, open forthright conduct by public officials should avoid much of the distress and acrimony which has surrounded this litigation.

Based upon the foregoing findings of fact and conclusions of law, the petition is in all respects dismissed. Respondent-intervenor's cross claim is dismissed.

Settle judgment.

Signed by Judge Harold Hyman

[3]4 Centers for Disease Control: Morbidity and Mortality Weekly Report, pp 245-8 [1985]

[2] New York Times, Linking AIDS to Africa Provokes Bitter Debate, November 21, 1985.

[1] New York Times, Our New Ravage of AIDS: Brain Damage, Science Times, October 15, 1985.

[4] Rubenstein, A: Acquired Immunodeficiency Syndrome In Infants, Am J Dis Child 1983; 137:825-7

[5]34 Centers for Disease Control, Current Trends: Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus: Morbidity and Mortality Weekly Report, pp 517-521 [Aug 30, 1985]

[6] New York Times, Pupils With AIDS a Risk, Koch Says, September 2, 1985.

[7] Most of these classified heterosexual contact AIDS cases are women who are the sexual partners of male intravenous drug users. While some male AIDS patients with no identified risk have given a history of multiple heterosexual contacts with female prostitutes, additional evidence for female to male transmission of HTLV-III/LAV in the United States is still being sought. Critics argue that men are not apt to admit past homosexual encounters or drug use; they further challenge the epidemiological data underlying one recent study suggesting female prostitutes in Central Africa are a high-risk group for transmitting HTLV-III/LAV infection and, in any event, the relevance of such a study to the spread of the infection among the heterosexual population in the United States.

[8] There is also one reported case outside the United States of transmission via breastfeeding.

[9] Consistent with the epidemiologic data and family studies indicating that casual transmission of HTLV-III/LAV does not occur are findings recently published in the New England Journal of Medicine demonstrating the infrequent isolation of HTLV-III/LAV virus from the saliva specimens of infected patients. Ho, D.D. Byington, RE, et al, Infrequency of Isolation of HTLV-III Virus From Saliva In AIDS, N Eng J Med, Dec 19, 1985, p 1606. The most extensive family study completed to date was reported within the past week, also in the New England Journal of Medicine, confirming that the virus could not be transmitted through causual contact. New York Times, Chief of Study on Victims' Families Doubts AIDS Is Transmitted Casually, February 6, 1985.

[10] As enacted by Chapter 626 of the Laws of 1971, the applicability of the State Sanitary Code as a minimum standard was extended to include New York City. Thus, the Public Health Council was given jurisdiction to participate constructively in the State Commissioner's statewide decisions which affect New York City. The City of New York, like other political subdivisions, still reserves the power to enact sanitary regulations [as appear in the Health Code] not inconsistent with the Sanitary Code (Public Health Law, section 228[2]) or state law (New York City Charter, section 558[b]).

[11] In Kokomo, Indiana, a 13 year old hemophiliac with AIDS has been attending school via telephone hookup while his lawyers exhaust four levels of state administrative appeals ordered in August by a Federal judge (*White v. Western School Corp.*, IP 85-1192-C, slip op [S.D. Ind., August 23, 1985.)

[12] The District Court noted that hepatitis B "is transmitted primarily by blood-to-blood contact, by means of transfusion of infected blood, or by use of a contaminated needle, although

some experts believe, but have not conclusively established, that it may also be transmitted through body fluids other than blood, such as saliva or semen." (*New York State Assn. for Retarded Children, Inc. v. Carey, supra*, p 489, n 1.)

" Since it appears that only epidemiological surveillance data is cloaked with absolute confidentiality (see discussion, *infra* XIII), the revelation of a child suspected of having AIDS or related conditions will in most cases come from outside referral sources, such as those delineated in the regulations on the committee for the Handicapped. (8 NYCRR 200.4[a].)

Source: Supreme Court of the State of New York for the County of Queens

APPENDIX I

Sections Of Federal Law Relating To The Education Of AIDS-Infected Children

EDUCATION OF THE HANDICAPPED ACT
P.L. 91-230

Part A—General Provisions

. . . Sec. 602.(a) As used in this title—

(1) The term "handicapped children" means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children or children with specific learning disabilities who by reason thereof require special education and related services. . . .

(15) The term "children with specific learning disabilities" means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain disfunction, dyslexia, and developmental aphasia. Such term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

(16) The term "special education" means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

(17) The term "related services" means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as

may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children. . . .

(20 U.S.C. 1401) Enacted April 13, 1970, P.L. 91-230, Title VI, sec. 602, 84 Stat. 175, amended November 29, 1975, P.L. 94-142, sec. 4(a), 89 Stat. 775, 776; amended December 2, 1983, P.L. 98-199, sec. 2, 97 Stat. 1357.

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974
P.L. 93-380

Protection Of The Rights And Privacy Of Parents And Students

Sec. 438.(a) . . .

(4)(A)For the purposes of this section, the term "education records" means, except as may be provided otherwise in subparagraph (B), those records, files, documents, and other materials, which—

(i) contain information directly related to a student; and (ii) are maintained by an educational agency or institution, or by a person acting for such agency or institution.

(B)The term "education records" does not include—

(i) records of instructional, supervisory, and administrative personnel and educational personnel ancillary thereto which are in the sole possession of the maker thereof and which are not accessible or revealed to any other person except a substitute:

(ii) if the personnel of a law enforcement unit do not have access to education records under subsection (b)(1), the records and documents of such law enforcement unit which (I), are kept apart from records described in subparagraph (A), (II) are maintained solely for law enforcement purposes, and (III) are not made available to persons other than law enforcement officials of the same jurisdiction;

(iii) in the case of persons who are employed by an educational agency or institution but who are not in attendance at such agency or institution, records made and maintained in the normal course of business which

relate exclusively to such person in that person's capacity as an employee and are not available for use for any other purpose; or

(iv) records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education, which are made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his professional or paraprofessional capacity, or assisting in that capacity, and which are made, maintained, or used only in connection with the provision of treatment to the student, and are not available to anyone other than persons providing such treatment, except that such records can be personally reviewed by a physician or other appropriate professional of the student's choice.

(5)(A) For the purposes of this section the term "directory information" relating to a student includes the following: the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student.

(B) Any educational agency or institution making public directory information shall give public notice of the categories of information which it has designated as such information with respect to each student attending the institution or agency and shall allow a reasonable period of time after such notice has been given for a parent to inform the institution or agency that any or all of the information designated should not be released without the parent's prior consent.

(b)(1) No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of education records (or personally identifiable information contained therein other than directory information, as defined in paragraph (5) of subsection (a) of students without the written consent of their parents to any individual agency, or organization, other than to the following—

(A) other school officials, including teachers within the educational institution or local educational agency, who have been determined by such agency or institution

to have legitimate educational interests;

(B) officials of other schools or school systems in which the student seeks or intends to enroll, upon condition that the student's parents be notified of the transfer, receive a copy of the record if desired, and have an opportunity for a hearing to challenge the content of the record;

(C)authorized representatives of (i) the Comptroller General of the United States, (ii) the Secretary [of Education], (iii) an administrative head of an education agency (as defined in section 408(c)), or (iv) State educational authorities, under the conditions set forth in paragraph (3) of this subsection;

(D) in connection with a student's application for, or receipt of, financial aid;

(E) State and local officials or authorities to whom such information is specifically required to be reported or disclosed pursuant to State statute adopted prior to November 19, 1974;

(F) organizations conducting studies for, or on behalf of, educational agencies or institutions for the purpose of developing, validating, or administering predictive tests, administering student aid programs, and improving instruction. If such studies are conducted in such a manner as will not permit the personal identification of students and their parents by persons other than representatives of such organizations and such information will be destroyed when no longer needed for the purpose for which it is conducted;

(G) accrediting organizations in order to carry out their accrediting functions;

(H) parents of a dependent student of such parents, as defined in section 152 of the Internal Revenue Code of 1954; and

(I) subject to regulations of the Secretary, in connection with an emergency, appropriate persons if the knowledge of such information is necessary to protect the health or safety of the student or other persons.

Nothing in clause (E) of this paragraph shall prevent a State from further limiting the number or type of State or local officials who will continue to have access thereunder.

(2) No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of releasing, or providing access to, any per-

sonally identifiable information in education records other than directory information, or as is permitted under paragraph (1) of this subsection, unless—

(A) there is written consent from the student's parents specifying records to be released, the reasons for such release, and to whom, and with a copy of the records to be released to the student's parents and the student if desired by the parents, or

(B) such information is furnished in compliance with judicial order, or pursuant to any lawfully issued subpoena, upon condition that parents and the students are notified of all such orders or subpoenas in advance of the compliance therewith by the educational institution or agency. . . .

(4)(A) Each educational agency or institution shall maintain a record, kept with the education records of each student, which will indicate all individuals (other than those specified in paragraph (1)(A) of this subsection), agencies, or organizations which have requested or obtained access to a student's education records maintained by such educational agency or institution, and which will indicate specifically the legitimate interest that each such person, agency, or organization has in obtaining this information. Such record of access shall be available only to parents, to the school official and his assistants who are responsible for the custody of such records, and to persons or organizations authorized in, and under the conditions of, clauses (A) and (C) of paragraph (1) as a means of auditing the operation of the system.

(B) With respect to this subsection, personal information shall only be transferred to a third party on the condition that such party will not permit any other party to have access to such information without the written consent of the parents of the student. . . .

(d) For the purposes of this section, whenever a student has attained eighteen years of age, or is attending an institution of postsecondary education the permission or consent required of and the rights accorded to the parents of the student shall thereafter only be required of and accorded to the student. . . .

(20 U.S.C. 1232(g) Enacted August 21, 1974, P.L. 93-380, sec. 513(a), 88 Stat 571, 574: amended December 31, 1974, P.L. 93-568, sec. 2, 88 Stat. 1858, 1860, amended Aug. 6, 1979, P.L.

96-46, sec. 4(c) 93 Stat. 342 (effective Oct. 1, 1978); see also general reference Oct. 17, 1979. P.L. 96-88, sec. 301, 93 Stat. 677.

Note: The Family Educational Rights and Privacy Act was enacted in 1974 as Section 438 of the General Education Provisions Act, P.L. 90-247.

REHABILITATION ACT OF 1973
P.L. 93-112

Definitions

Sec. 7. For the purposes of this Act: . . .

(7)(A) Except as otherwise provided in subparagraph (B), the term "handicapped individual" means any individual who (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services provided pursuant to titles I and III of this Act.

(B) Subject to the second sentence of this subparagraph, the term "handicapped individual" means, for purposes of titles IV and V of this Act, any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. For purposes of sections 503 and 504 as such sections relate to employment, such term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others. . . .

(29 U.S.C. 706) Enacted September 26, 1973, P.L. 93-112, sec. 7. . . .

Nondiscrimination Under Federal Grants And Programs

Sec. 504. No otherwise qualified handicapped individual in the United States, as defined in section 7(7), shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. . . .

(29 U.S. C. 794) Enacted September 26, 1973, P.L. 93-112, sec. 504.

APPENDIX J
AIDS-Related Associations

The following is a select list of national, state and local organizations dealing with the AIDS crisis. Groups listed are available to provide information on AIDS. More information may be obtained by contacting your state or local health departments.

National Groups

AIDS Action Council/Federation of AIDS-Related Organizations
729 8th St. SE, # 200
Washington, D.C. 20003
(202)547-3101

AIDS Education Fund
2335 18th St. NW
Washington, D.C. 20009
(202)332-5939

American Foundation for AIDS Research
9601 Wilshire Blvd., Mezzanine
Los Angeles, Calif. 90210
(213)273-5547

Lambda Legal Defense and Education Fund
132 W. 43rd St.
New York, N.Y. 10036
(212)944-9488

National Coalition of Gay and Sexually Transmitted Disease Services
P.O. Box 239
Milwaukee, Wis. 53201
(414)277-7671

National Institute of Allergies and Infectious Diseases
Information Office
Bldg. 31, Room 7A32
Bethesda, Md. 20205
(301)496-5717

U.S. Centers for Disease Control
AIDS Activity Office
1600 Clifton Road NE
Atlanta, Ga. 30333
(404)329-3472

U.S. Conference of Mayors
1620 I St. NW
Washington, D.C. 20006
(202)293-7330

Arkansas

Get Yourself Together House
4201 Barrow Road
Little Rock, Ark. 72204
(501)568-1682

Psychotherapy Center
409 Walnut St.
Little Rock, Ark. 72205
(501)663-6455

California

AIDS Interfaith Network
890 Hayes St.
San Francisco, Calif. 94117
(415)928-HOPE

AIDS/Kaposi's Sarcoma Foundation
1900 K St., # 201
Sacramento, Calif. 95814
(916)448-AIDS

AIDS/Oncology Clinic
San Francisco General Hospital
995 Potrero
Ward 86
San Francisco, Calif. 94110
(415)821-8830

AIDS Project Los Angeles
7362 Santa Monica Blvd.
West Hollywood, Calif. 90046
(213)876-8951

AIDS Team
P.O. Box 9773
Fresno, Calif. 93794
(209)264-2436

Bay Area Physicians for Human Rights
P.O. Box 14546
San Francisco, Calif. 94114
(415)558-9353

Berkeley Gay Men's Clinic
2339 Durrant Ave.
Berkeley, Calif. 94704
(415)644-0425

Gay and Lesbian Community Services of Orange County
12832 Garden Grove Blvd., Suite E
Garden Grove, Calif. 92643
(714)534-0862

Pacific Center AIDS Project
P.O. Box 908
Berkeley, Calif. 94701
(415)548-8283

Sacramento AIDS Foundation
1900 K St., # 201
Sacramento, Calif. 95814
(916)448-2437

San Diego AIDS Project
4304 Third Ave.
P.O. Box 89049
San Diego, Calif. 92138
(619)543-0300

San Francisco AIDS Foundation
333 Valencia St., 4th Floor
San Francisco, Calif. 94103
(415)864-4376

Shanti Project
890 Hayes St.
San Francisco, Calif. 94117
(415)558-9644

Colorado

Colorado AIDS Project
P.O. Box 18529
Denver, Colo. 80218
(303)837-0166

Denver Disease Control
605 Bannock St., Room 120
Denver, Colo. 80204
(303)893-7051

Connecticut

AIDS Project Hartford
350 Farmington Ave.
Wethersfield, Conn. 06109
(203)247-2437

AIDS Project New Haven
P.O. Box 636
New Haven, Conn. 06503
(203)624-0947

Florida

AIDS Center One
604 S.W. 12th Ave.
Ft. Lauderdale, Fla. 33312
(305)764-3123

AIDS Education Project
P.O. Box 4073
Key West, Fla. 33041
(305)294-8302

Health Crisis Network
P.O. Box 52-1546
Miami, Fla. 33152
(305)634-4780

Georgia

AID Atlanta
811 Cypress St. NE
Atlanta, Ga. 30308
(404)872-0600

Hawaii

Life Foundation
320 Ward Ave., # 104
Honolulu, Hawaii 96814
(808)924-2437

Illinois

Howard Brown Memorial Clinic
2676 N. Halsted
Chicago, Ill. 60614
(312)871-5777

Sable/Sherer Clinic
Division of General Medicine
1835 W. Harrison St.
Chicago, Ill. 60612
(312)633-7810

Indiana

Indianapolis AIDS Task Force
c/o Community Hospital
1500 N. Ritter
Indianapolis, Ind. 46219
(317)353-1411

Louisiana

AIDS Information Center
904 Bourbon St.
New Orleans, La. 70116
(504)522-2437

Maryland

Baltimore Gay Community Center
241 W. Chase St.
Baltimore, Md. 21201
(301)837-5445

HERO/Medical Arts Bldg.
Cathedral and Read, # 819
Baltimore, Md. 21201
(301)685-1180

Massachusetts

AIDS Action Committee
661 Boylston St., Suite 4
Boston, Mass. 02116
(617)437-6200

Fenway Health Community Center/AIDS Action Committee
16 Haviland St.
Boston, Mass. 02115
(617)267-7573

Mayor's Committee on AIDS
Boston City Hall, Room 709A
Boston, Mass. 02201
(617)725-3485

Michigan

Wellness Networks Inc.
P.O. Box 1046
Royal Oaks, Mich. 48068
(313)876-3582

Minnesota

Minnesota AIDS Project
P.O. Box 300122
Minneapolis, Minn. 55403
(612)870-7773

Mississippi

Mississippi Gay Alliance
P.O. Box 8342
Jackson, Miss. 39204
(601)353-7611

Missouri

St. Louis Task Force on AIDS
4532 Lindell
St. Louis, Mo. 63108
(314)367-1140

New Jersey

New Jersey Lesbian/Gay Coalition
St. Michael's Medical Center
268 High St.
Newark, N.J. 07102
(201)877-5000

New Mexico

New Mexico AIDS Services
209A McKenzie St.
Sante Fe, N.M. 87501
(505)984-0911

New Mexico Physicians for Human Rights
Santa Fe, N.M. 87532
(505)984-1217

New York

AIDS Council of Northeastern New York
315 Hamilton St.
Albany, N.Y. 12210
(518)434-4686

AIDS Institute
New York State Department of Health
10 E. 40th St., 11th Floor
New York, N.Y. 10016
(212)340-3388

AIDS Medical Foundation
40 W. 57th St., Room 406
New York, N.Y. 10019
(212)333-3118

AIDS Network Group
Department of Social Work
Memorial Sloan-Kettering Institute
1275 York Ave.
New York, N.Y. 10021
(212)794-7018

AIDS Program, Haitian Centers Council
50 Court St., Suite 605
Brooklyn, N.Y. 11201
(718)855-7275

AIDS Resource Center
Chelsea Station
P.O. Box 792
New York, N.Y. 10011
(212)206-1414

AIDS Rochester Inc.
133 Liberty Pole Way
Rochester, N.Y. 14604
(716)232-7181

AIDS Task Force
Broome County Health Department
1 Wall St.
Binghamton, N.Y. 13901
(607)772-2857

AIDS Task Force
255 Grove St.
White Plains, N.Y. 10601
(914)997-5149

AIDS Task Force of Central New York
P.O. Box 1911
Syracuse, N.Y. 13201
(315)475-2430

Gay Men's Alliance of Hudson Valley/AIDS Task Force
255 Grove St.
White Plains, N.Y. 10601
(914)997-5149

Gay Men's Health Crisis
132 W. 24th St.
P.O. Box 274
New York, N.Y. 10011
(212)807-7035

Long Island AIDS Project
SAHP/HSC
SUNY at Stony Brook
Stony Brook, N.Y. 11794
(516)444-2403

Mayor's Interagency Task Force on AIDS
125 Worth St., Room 322
New York, N.Y. 10013
(212)566-0808

New York City Health Department
455 1st Ave.
New York, N.Y. 10016
(718)485-8111

Southern Tier AIDS Program
P.O. Box 1492
Binghamton, N.Y. 13902
(607)723-6493

Western New York AIDS Program
P.O. Box 38, Bidwell Station
Buffalo, N.Y. 14222
(716)881-2438

North Carolina

Lesbian and Gay Health/AIDS Project
P.O. Box 11013
Durham, N.C. 27703
(919)286-0079

Ohio

Columbus AIDS Task Force
P.O. Box 8393
Columbus, Ohio 43201
(614)297-0411

Health Issues Task Force
P.O. Box 14925
Public Square Station
Cleveland, Ohio 44114
(216)651-1448

Ohio Department of Health
246 N. High St.
Columbus, Ohio 43216
(614)466-3543

Oklahoma

Gay Health Clinic
4107 E. 2nd Place
Oklahoma City, Okla. 74112
(405)528-4297

Oregon

Cascade AIDS Project
408 S.W. 2nd Ave., Room 403
Portland, Ore. 97204
(503)223-5907

Pennsylvania

Philadelphia AIDS Task Force
P.O. Box 7259
Philadelphia, Pa. 19101
(215)732-AIDS

Tennessee

Nashville CARES
P.O. Box 25107
Nashville, Tenn. 37202
(615)321-0118

Texas

Austin AIDS Project
P.O. Box 4874
Austin, Texas 78765
(512)452-5966

Kaposi's Sarcoma/AIDS Foundation
3317 Montrose
P.O. Box 1155
Houston, Texas 77006
(713)524-2437

Mayor's AIDS Task Force
City of Houston
P.O. Box 1562
Houston, Texas 77251
(713)222-4005

Oak Lawn Counseling Center
5811 Nash St.
Dallas, Texas 75235
(214)351-1502

Virginia

Richmond AIDS Information
Fan Free Clinic
1721 Hanover Ave.
Richmond, Va. 23219
(804)358-6343

Dr. Robert Weigle
1035 Providence Square
Virginia Beach, Va. 23464
(804)495-2961

Washington

Northwest AIDS Foundation
P.O. Box 3499
Seattle, Wash. 98114
(206)587-0306

Seattle AIDS Action Committee
700 A East Parkway
Seattle, Wash. 98122
(206)323-1229

Seattle Gay Clinic
402 15th Ave. East
Seattle, Wash. 98122
(206)322-287

APPENDIX K

American Academy Of Pediatrics
State Chapter Chairmen Available For Information On AIDS

Alabama

Thomas Nolan, M.D., Chairman
P.O. Box 928
Troy, Ala. 36081
(205)566-7600

Ted Williams, M.D., Alternate Chairman
1105 W. Main St.
Dothan, Ala. 36301
(205)794-8656

Alaska

Clinton Lillibridge, M.D., Chairman
4001 Dale St., Suite 118
Anchorage, Alaska 99508
(907)563-1948

Thomas Porter, M.D., Alternate Chairman
USPHS-ANMC Box 7-741
Anchorage, Alaska 99510
(907)279-6661

Arizona

Michael Cohen, M.D., Chairman
529 W. Wetmore Road
Tucson, Ariz. 85705
(602)887-2506

Herbert Winograd, M.D., Alternate Chairman
4232 E. Cactus Road
Phoenix, Ariz. 85032
(602)996-7900

Arkansas

Horace Green, M.D., Chairman
1420 W. 43rd Ave.
Pine Bluff, Ark. 71603
(501)534-6210

Rex Ramsay, M.D., Alternate Chairman
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Bauxite, Ark. 72011
(501)778-3644

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Robert Black, M.D., Alternate Chairman
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Monterey, Calif. 93940
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California, Chapter 2

Elmore Lewis, M.D., Chairman
10720 Paramount Blvd.
Downey, Calif. 90241
(213)923-6511

Anthony Hirsch, M.D., Alternate Chairman
414 N. Boyle Ave.
Los Angeles, Calif. 90033
(213)268-5000

California, Chapter 3

Leonard Kornreich, M.D., Chairman
685 Third Ave.
Chula Vista, Calif. 92010
(619)425-2151

Louie Linarelli, M.D., Alternate Chairman
7930 Frost St., Suite 401
San Diego, Calif. 92123
(619)294-8111

California, Chapter 4

Paul Qaqunduh, M.D., Chairman
17822 Beach Blvd.
Huntington Beach, Calif. 92647
(714)842-1441

Norah Gutrecht, M.D., Alternate Chairman
801 N. Tustin, # 205
Santa Ana, Calif. 92705
(714)558-4811

Colorado

Donald Cook, M.D., Chairman
1650 16th St.
Greeley, Colo. 80631
(303)352-8304

James Shira, M.D., Alternate Chairman
Children's Hospital
1056 E. 19th Ave.
Denver, Colo. 80218
(303)861-6130

Connecticut

E. Maurice Wakeman, M.D., Chairman
152 Broad St.
Guilford, Conn. 06437
(203)453-5235

Leonard Krassner, M.D., Alternate Chairman
116 Sherman Ave.
New Haven, Conn. 06511
(203)789-3737

Delaware

Maurice Liebesman, M.D., Chairman
1202 Foulk Road
Wilmington, Del. 19803
(302)762-6222

Joseph Vitale, D.O., Alternate Chairman
110 Christiana Medical Center
Newark, Del. 19702
(302)368-8612

District of Columbia

Guillermo Balfour, M.D., Chairman
3301 New Mexico Ave. NW, Suite 238
Washington, D.C. 20016
(202)537-1180

John Chamberlain, M.D., Alternate Chairman
5301 Westbard Circle
Washington, D.C. 20816
(202)654-6303

Florida

Arnold Tanis, M.D., Chairman
4500 Sheridan St.
Hollywood, Fla. 33021
(305)966-8000

John Whitcomb, M.D., Alternate Chairman
Sacred Heart Hospital
5151 N. Ninth Ave.
Pensacola, Fla. 32504
(904)476-7851 or 474-7000

Georgia

Joseph Morrison Jr., M.D., Chairman
4 Medical Arts Center
Savannah, Ga. 31499
(912)355-2462

Albert Pruitt, M.D., Alternate Chairman
Department of Pediatrics
Medical College of Georgia
Augusta, Ga. 30912
(404)828-3466

Hawaii

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1314 S. King St., Suite 414
Honolulu, Hawaii 96814
(808)946-6088

Fernando Atienza, M.D., Alternate Chairman
321 N. Kuakini St.
Honolulu, Hawaii 96817
(808)526-0434

Idaho

Hal Davis, M.D., Chairman
9th and Oxford Dr.
Idaho Falls, Idaho 83401
(208)523-3060

Ben Katz, M.D., Alternate Chairman
284 Martin St.
Twin Falls, Idaho 83301
(208)733-9140

Illinois

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2138 E. 75th St.
Lock Box 426
Chicago, Ill. 60649
(312)633-7292

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Quincy, Ill. 62301
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University of Iowa Hospitals
Iowa City, Iowa 52242
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Jack Swanson, M.D., Alternate Chairman
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12th and Douglas
Ames, Iowa 50010
(515)239-4400

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Ben Rubin Jr., M.D., Chairman
132 S. 17th St.
Kansas City, Kansas 66102
(913)371-2561 or 334-6900

Virginia Tucker, M.D., Alternate Chairman
1517 Indian Wells Court
Lawrence, Kansas 66044
(913)842-9313

Kentucky

Charles Taylor, M.D., Chairman
120 N. Eagle Creek Dr., Suite 140
Lexington, Ky. 40509
(606)269-3362

Donald Cantley, M.D., Alternate Chairman
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(502)827-3573

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James Reynolds, M.D., Alternate Chairman
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(504)899-5080

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Augusta, Maine 04430
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Bath, Maine 04530
(207)443-5544

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Towson, Md. 21204
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Timonium, Md. 21093
(301)252-1781

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Fall River, Mass. 02724
(617)675-2131

Eileen Ouellette, M.D., Alternate Chairman
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Newton Center, Mass. 02159
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Hutzel Hospital Professional Bldg.
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Southfield, Mich. 48076
(313)559-6632

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Mayo Memorial Bldg., Box 483
University of Minnesota School of Medicine
Minneapolis, Minn. 55455
(612)376-4009

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Minneapolis, Minn. 55422
(612)588-0758 or 559-2861

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Jackson, Miss. 39202
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Dale Jeanette Pullen, M.D., Alternate Chairman
2500 N. State St.
Jackson, Miss. 39216
(601)693-2441

Missouri

David Simon, M.D., Chairman
9705 Watson Road
St. Louis, Mo. 63126
(314)966-0626

Nirmal Mitra, M.D., Alternate Chairman
11201 Colorado
Kansas City, Mo. 64137
(816)761-0775

Montana

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1930 9th Ave.
Helena, Mont. 59601
(406)442-9523

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7 E. Beall
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(402)397-5509

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Hastings, Neb. 68901
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Reno, Nev. 89503
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Burton Dudding, M.D., Alternate Chairman
350 W. 6th St., Suite 2-A
Reno, Nev. 89503
(702)329-2525

New Hampshire

Spencer Brody, M.D., Chairman
111 Church St.
Laconia, N.H. 03246
(603)524-4430

Steven Kairys, M.D., Alternate Chairman
Dartmouth-Hitchcock Medical Center
Hanover, N.H. 03755
(603)643-3994 or 646-5000

New Jersey

William Van Ost, M.D., Chairman
151 N. Dean St.
Englewood, N.J. 07631
(201)567-3322

Joseph Bogdan, M.D., Alternate Chairman
2100 Corlies Ave.
Neptune, N.J. 07753
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New Mexico

Michael Nelson, M.D., Chairman
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Albuquerque, N.M. 87114
(505)898-6001

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Children's Clinic, PA
Medical Center
Los Alamos, N.M. 87544
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Jamaica Hospital
89th Ave. and Van Wyck Expy.
Jamaica, N.Y. 11418
(718)657-1800

New York, Chapter 3

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Albert Einstein College of Medicine
Bronx, N.Y. 10461
(212)597-8500

Donald Gromisch, M.D., Alternate Chairman
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Syosset, N.Y. 11791
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3709 St. Regis Dr.
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Charlotte, N.C. 28232
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Grand Forks Clinic
1000 Columbia Road
Grand Forks, N.D. 58201
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Ohio

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700 Children's Dr.
Columbus, Ohio 43205
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1 Mt. Sinai Dr.
Cleveland, Ohio 44106
(216)421-4099

Oklahoma

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Chickasha Clinic, P.O. Box 1069
Chickasha, Okla. 73018
(405)224-7413

Howard Scott, M.D., Alternate Chairman
4720 S. Harvard, Suite 112
Tulsa, Okla. 74135
(918)743-6441

Oregon

Allen Harlor Jr., M.D., Chairman
155 W. A St.
Springfield, Ore. 97477
(503)747-8532

Bruce Strimling, M.D., Alternate Chairman
750 E. 11th St.
Eugene, Ore. 97401
(503)686-2978

Pennsylvania

Susan Aronson, M.D., Chairman
605 Moreno Road
Narberth, Pa. 19072
(215)664-3923

Alan Kohrt, M.D., Alternate Chairman
Child Health Associates
Wallenpaupack Medical Foundation
Tafton, Pa. 18464
(717)226-4525

Puerto Rico

Jose Pascual-Baralt, M.D., Chairman
400 Domenech Ave., Suite 302
Hato Rey, P.R. 00918
(809)763-3055

Pedro Jaunarena, M.D., Alternate Chairman
520 J.J. Jimenez St.
Hato Rey, P.R. 00918
(809)764-3737

Rhode Island

Alfred Toselli, M.D., Chairman
293 Governor St.
Providence, R.I. 02906
(401)421-5126

Victor Lerish, M.D., Alternate Chairman
Barrington Pediatric Association Inc.
1525 Wampanoag Trail
Riverside, R.I. 02915
(401)433-1600

South Carolina

C. Warren Derrick Jr., M.D., Chairman
USC School of Medicine, Pediatrics
3301 Harden St.
Columbia, S.C. 29203
(803)765-7211

Jack Rheney Jr., M.D., Alternate Chairman
620 Carolina Ave. NE
Orangeburg, S.C. 29115
(803)534-1404

South Dakota

Jon Flom, M.D., Chairman
702 W. 9th St.
Yankton, S.D. 57078
(605)677-5292

Willis Sutliff, M.D., Alternate Chairman
Black Hills Pediatrics
2929 5th St., Suite 250
Rapid City, S.D. 57701
(605)341-7337

Tennessee

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Source: American Academy of Pediatrics

APPENDIX L

Glossary Of AIDS-Related Terms

AIDS (Acquired Immune Deficiency Syndrome): An infectious disease characterized by a breakdown of the body's immune system, believed to be caused by the virus HTLV-III (human T-cell lymphotropic virus, type III). The acquired deficiency in the immune system opens the body to infection by microorganisms that usually are unable to penetrate normal immune systems (see Pneumocystis carinii pneumonia) or to a rare form of cancer (see Kaposi's sarcoma).

ARC (AIDS-Related Complex): The chronic occurrence of nonspecific symptoms and physical conditions that appear to be related to, or caused by, AIDS. Signs of ARC may consist of enlargement of the lymph nodes, recurrent fevers, weight loss, minor alterations in the immune system and minor infections. Individuals suffering from ARC may develop AIDS, or they may never proceed beyond the ARC stage.

Antibody: A protein produced by white blood cells to fight bacteria, viruses and other germs and foreign bodies. Antibodies help the body prevent some diseases and recover from others. Also called immunoglobulins.

Antigen: Any substance that provokes an immune response when introduced into the body.

B-Cells (B Lymphocytes): One of the two types of white blood cells that control immune reactions. B-cells are derived from bone marrow and are involved in the production of antibodies.

Chromosomes: Threadlike structures in the nucleus of a cell that carry genetic information. Each consists of a double strand of twisted DNA.

Core Proteins: Proteins that make up the internal structure of a virus.

Cytopathic: Pertaining to, or characterized by, abnormal changes in body cells.

Dermatitis: Inflammation of the skin.

DNA (Deoxyribonucleic Acid): The chromosome molecule of a cell that carries genetic information.

ELISA Test (Enzyme-Linked Immunosorbent Assay): The laboratory test for antibodies to the AIDS virus. Results are seropositive if they show antibody response to the virus, or seronegative if they show lack of antibody response to the virus. Use of the test protects the blood supply from contamination by identifying AIDS-infected donors.

Endoscopic: Related to the visual inspection of the inside of organs or cavities of the body.

Envelope Proteins: Proteins that make up the surface of a virus.

Enzyme: A protein produced by living cells that speeds up or causes chemical reactions in living matter. Enzymes themselves are not altered or destroyed by the reactions.

Epidemiology: The study of the spread, prevention and control of disease in a community or group of persons. Epidemiologic studies examine the relationships of factors that determine the frequency and occurrence of specific diseases.

Etiologic Agent: Factor involved in the cause of a disease.

Exudative: Oozing fluid from cells and tissues.

Factor VIII: A blood-clotting protein found in normal blood plasma. Lack of the protein results in the bleeding disease hemophilia. A concentration of factor VIII is used to treat hemophiliacs.

Gene: The cell unit that carries biological information determining hereditary characteristics. Genes are located along the length of each of a cell's strands of DNA.

Hemophilia: A hereditary bleeding disorder caused by the deficiency of a factor needed to clot the blood. (See Factor VIII.)

Hepatitis: An inflammation of the liver that may be caused by many factors, including viruses transmitted through blood

transfusions. Severe cases may result in permanent liver damage.

HPA-23 (Heteropolytungstate): A drug that has been used in early clinical trials in an effort to inhibit the growth of HTLV-III in humans, but has not been shown to destroy the virus.

HTLV-III (Human T-Cell Lymphotropic Virus, Type III): The virus identified in 1984 as the cause of AIDS. The virus attacks the T-4 (helper) cells, which regulate the immune system. (See LAV.)

Immune System: The body's protection against diseases and other foreign bodies.

Immunodeficient: Abnormal weakness of the immune system resulting in decreased resistance to infection.

Immunosuppressed: Condition in which the body's immune response is impaired as a result of disease, infection, malnutrition, stress, etc.

Interferon: A substance produced and released into the bloodstream by T lymphocytes and capable of stimulating other cells in the immune system. Interferon protects cells from infection.

Interleukin-II: A body substance normally found in tiny amounts that stimulates some white blood cells to fight germs and cancer cells.

In Vitro: From the Latin, meaning "in glass." *In vitro* biological reactions are created artificially in laboratory apparatus.

In Vivo: From the Latin, meaning "in the living." *In vivo* biological reactions take place in living organisms.

Kaposi's Sarcoma: A spreading cancer that affects the lining of the capillaries, usually involving the skin, and formerly seen only rarely in older men. Now seen frequently in AIDS patients, in whom the cancer spreads to internal organs as well.

LAV (Lymphadenopathy-Associated Virus): A virus found by

French scientists in a patient suffering from lymphadenopathy, or enlarged lymph nodes, who also was in an AIDS high-risk group. The virus now is believed to be the same as HTLV-III.

Lymph Nodes: Small organs of the immune system that filter body fluids, fight infection and produce white blood cells and blood plasma cells. Most nodes are clustered in the neck, armpit, abdomen and groin.

Lymphocyte: Small white blood cells normally present in blood and lymphoid tissue that bear the major responsibility for carrying out the functions of the immune system. (See B-Cells, T-Cells.)

LAS (Lymphadenopathy Syndrome): A condition similar to ARC, characterized by enlargement of the lymph nodes and sometimes accompanied by fever and weight loss. Some LAS patients have developed AIDS.

Mycobactericidal: Having the ability to kill the kind of bacteria known to cause tuberculosis and leprosy.

Opportunistic Infections: Diseases or infections that normally do not affect persons with healthy immune systems, but which take advantage of a body's weakened immunity. (See Pneumocystis carinii pneumonia.)

Parenteral: Introduction of a substance into the body through means other than the digestive system (i.e., by injection).

Passive Immunity: Acquired immunity achieved by administration of antibody from one person to another.

Perinatal: The time and process of giving birth or being born. The perinatal period lasts from the 28th week of pregnancy to 28 days after birth.

Pneumocystis Carinii Pneumonia: A lung infection caused by protozoa, which strikes about two-thirds of all AIDS patients and can be fatal if left untreated.

Pre-AIDS: Now called ARC.

Provirus: The gene set of a virus that takes over the chromosome

of a host cell and reproduces itself through all of the host's daughter cells. (See retrovirus.)

Retrovirus: A virus that contains RNA instead of DNA and uses an enzyme called reverse transcriptase to replace a host cell's DNA with its own genetic information. The resulting invaded and altered cell is a provirus.

Ribavirin: A drug that has been tested *in vitro* to inhibit HTLV-III infection. Ribavirin is being evaluated in AIDS patients.

RNA (Ribonucleic Acid): An acid found in cells that carries genetic information from the nucleus to the rest of the cell.

Seroconversion: The development of antibodies in response to challenge by an antigen.

Serologic: Pertaining to the study of antigen-antibody reactions.

Seronegative: See ELISA Test.

Seropositive: See ELISA Test.

Serum: The clear portion of an animal liquid separated from its solid parts. Blood serum separates in the clotting of blood. Serum of patients suffering from a disease can be used to provide passive immunity against the same disease when injected into others.

Suramin: A drug that has been used *in vitro* to inhibit growth of HTLV-III. Suramin is being tested in AIDS patients.

T-Cell Growth Factor (TCGF): See Interleukin-II.

T-Cells (T Lymphocytes): White blood cells that mature in the thymus gland. They do not secrete antibodies, but their help is essential for antibody production. Some T-cells become "helper cells" (see T-4 Cells) that turn B-cells or other T-cells on, while others become "suppressors" that turn the cells off.

T-4 Cells: The focal cells of the immune system. AIDS patients characteristically have depleted supplies of T-4 Cells.

Vaccine: A preparation of dead or weakened germs introduced into the body to produce or stimulate immunity to a disease.

Virus: A submicroscopic organism that causes disease. The individual particles, which reproduce only in living cells, are composed of nucleic acid, either DNA or RNA, and a protein shell or coat.

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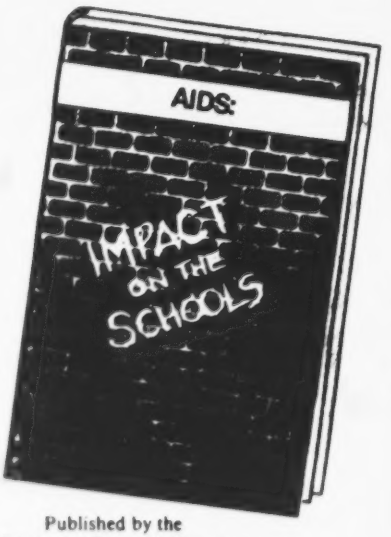

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>
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